GP Access to Community Diagnostics Scheme: An External Evaluation

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tasc
25 years

ACKNOWLEDGEMENTS

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List of Abbreviations

CT	Computer Tomography
DEXA	Dual-Energy X-ray Absorptiometry
DOH	Department of Health
GP	General Practitioner
GPACD	GP Access to Community Diagnostics
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
MRI	Magnetic Resonance Imaging
NIMIS	National Integrated Medical Imaging System
NTPF	National Treatment Purchase Fund
RCSI	Royal College of Surgeons Ireland
SDG	Sustainable Development Goals

Executive Summary

A variety of stakeholders were consulted as part of an independent assessment of the General Practitioner Access to Community Diagnostic (GPACD) scheme. These stakeholders participated in various parts of the patient's journey: patients, patient advocates, general practitioners (GPs), radiologists and specialist consultants.

As a whole, the GPACD scheme has demonstrably improved timely access to diagnostic imaging, notably MRI scans, for public patients, leading to reduced wait times, fewer emergency and outpatient referrals, and enhanced referral quality through allowing for imaging to occur prior to a specialist appointment. Both qualitative interviews and quantitative surveys affirm that patients receive scan results within weeks to months, enabling more effective clinical management and earlier diagnosis, particularly in underserved and deprived areas.

However, among the stakeholders, GPs and patients were the only groups to unanimously support the scheme. Interviews with other stakeholders who were working in public hospitals, reveal systemic challenges that extend beyond immediate access to diagnostic imaging. Chiefly, they described bottlenecks due to resource constraints in public hospitals, leading to prolonged waits for follow-up scans and specialist consultations. Consultants and radiologists also describe concerns around scan quality and persistent issues around system integration, as private scan reports often lack clinical context, are inconsistently linked to national imaging systems, and limit direct communication between GPs and radiologists. These factors contribute to inefficiencies, repeated scans, and patient anxiety, particularly when ambiguous or incidental findings arise.

GPs highlighted that equity concerns are pronounced. Patients with limited English proficiency or digital access face significant hurdles navigating the scheme, compounded by a lack of interpreter services and translated materials from private providers. Geographic and transportation barriers disproportionately affect rural and socioeconomically disadvantaged populations, further challenging equitable access.

While GPs express high overall satisfaction with the scheme's ability to expedite diagnostics and reduce hospital demand, they also mentioned that the scheme increased the workload for primary care providers. This increased workload was seen to be driven by the need to interpret complex scan reports, manage follow-ups, and respond to referrals redirected from hospital services. GPs also mentioned that communication with private scan providers varies significantly; preferred providers are praised for accessibility and

responsiveness, while others struggle, especially in supporting vulnerable patients facing language and digital literacy barriers.

During the initial development of the scheme and subsequent expansions, a critical gap exists in stakeholder engagement and governance. Frontline clinicians (both GPs and specialist consultants) report minimal consultation by the Health Service Executive during scheme design and implementation, unclear guidelines, and absence of systematic audits evaluating cost-effectiveness, clinical outcomes, and provider performance. This has fuelled frustration and uncertainty about the scheme's long-term sustainability and accountability, especially given its reliance on private providers funded by public resources.

Looking forward, stakeholders emphasise the need for strategic, measured expansion of diagnostic capacity that balances cost-effectiveness, clinical appropriateness, and sustainability. Investment in public diagnostic infrastructure, integration of private providers into national imaging systems, enhanced GP education, and deployment of clinical decision support tools are key priorities. Such mechanisms are essential to ensure equitable access and patient-centred care.

In summary, while the GPACD scheme has delivered important improvements in diagnostic access and patient management, its continued success depends on systemic enhancements in quality assurance, governance, equity, and integration across the healthcare continuum.

1. Introduction

1.1 Irish Health System Overview

Ireland's health system is marked by a complex interplay between public and private providers and funders (European Commission, 2025). The Department of Health (DOH) oversees overall stewardship of healthcare provision, sets policy direction, and monitors performance, including the allocation of the health budget, while the Health Service Executive (HSE) is responsible for the management and delivery of publicly funded health and social care services (European Commission, 2025).

Public healthcare is primarily financed through taxation, with residency status and means tests determining service access (European Commission, 2025). Significant capacity limitations in public outpatient and inpatient services have led over 45% of the population to purchase voluntary health insurance for faster access to care and partial coverage of copayments (European Commission, 2025).

Systemic attempts at addressing inadequate public capacity by the HSE have involved the purchase of services from general practitioners (GPs), dentists, pharmacists, allied health professionals, voluntary hospitals, voluntary community organisations, private hospitals and private homecare agencies (European Commission, 2025). Thus, a suite of private providers plays key roles in the delivery of primary, acute and long-term care.

1.2 Primary Care Entitlements

In Ireland, entitlement to accessing free healthcare is complex and relates to an individual's residency status, financial means and health status (TASC, 2025). The average cost of a GP consultation is €52.50, with fees covered by public funds for patients with a medical card or GP visit card (TASC, 2025). As of October 2024, it was estimated that approximately 42% of the population had access to free GP care through either medical cards or GP visit cards (Oireachtas, 2024b).

1.3 Waiting Lists for Diagnostics

Working in primary care, GPs play a critical role in diagnostics referrals. Patients often present to their GPs with a range of symptoms and it is the role of the GP to conduct an initial oral and medical assessment of these symptoms, gather the patient's medical history, and refer the patient to specialist diagnostic services as appropriate. Traditionally, the diagnostic referrals from GPs would have been sent to hospital services.

Historically, lack of access to diagnostic services and long delays in the public system have left GPs with no option but to refer patients to emergency departments or inpatient care (O'Riordan et al., 2013). In order to address this, moves to increase GP access to diagnostic services have been in place since 2007, when a community-based diagnostic initiative was introduced, with the aim of increasing patients' access to ultrasound and X-rays through their GP. Evaluation of this programme indicated that it had resulted in decreased waiting times and improved access for patients (O'Riordan et al., 2013).

1.4 GP Access to Community Diagnostics

The GP Access to Community Diagnostics (GPACD) scheme (HSE, 2025a) was established in 2021 to enable GPs in Ireland to directly refer adult patients to diagnostic tests within community settings, in an effort to reduce the need for hospital referrals (HSE, 2024). The GPACD rollout has been phased, with expansions to service access occurring in order to increase geographic coverage and accessibility for patients. There are no limits on the number of referrals that a GP can make under the scheme (Wall, 2024).

The GPACD scheme aligns with the long-term objectives of Sláintecare, in that it provides options to shift healthcare delivery more towards community-based services and seeks to improve timely access to diagnostics tests for patients holding medical or GP visit cards. This policy background emphasises enhancing efficiency, patient convenience, and integration of diagnostics into general practice to alleviate pressure on hospitals and improve patient outcomes.

The GPACD scheme allows GPs to refer patients of ages 16 or older to radiology diagnostics (e.g. X-ray, computer tomography (CT), magnetic resonance imaging (MRI), dual-energy X-ray absorptiometry (DEXA) and ultrasound services) and diagnostic tests (e.g. Echocardiography, Spirometry and NT-proBNP) via approved private providers (HSE, 2025a, 2025b). Patients who do not have access to free healthcare (e.g. through a medical card) need to pay for the cost of the GP appointment. The radiology diagnostic and/or diagnostic test is free-of-charge, however. Patients are referred to the scheme via the Healthlink platform (eHealth Ireland, 2024), although this has not always been the case as referrals have depended on the infrastructure of private providers[1]. Private providers then bill the HSE monthly for the cost of the performed scans. Delivered through approved private providers, the aim is that urgent referrals are addressed within one month and routine referrals within three months (HSE, 2025c; Oireachtas, 2025). A further description of diagnostic imaging in Ireland is available in Appendix 1.

[1] For example, according to past versions of HSE documentation, prior to August 2023, Global Diagnostics/Medica only accepted referrals via fax or email.

The GPACD scheme can be characterised as outsourcing diagnostic imaging services to private providers (Lynch, 2023) while maintaining public funding and GP referral control. This approach helps expand access to diagnostics in the community without requiring all services to be delivered directly by public hospitals. The objectives of this, as outlined in HSE and Government publications, focus on enhancing patient care and improving healthcare system efficiency. Key aims include improving the quality of services provided to patients by ensuring timely access to diagnostic investigations and accelerating the speed of diagnosis, thereby enhancing the overall patient experience (DOH, 2024; HSE, 2025a). Additionally, the programme seeks to reduce pressure on the acute care system by decreasing presentations to emergency departments, lowering both outpatient and inpatient hospital admissions, and shortening waiting lists in terms of patient volume and waiting times for procedures (HSE, 2021; Oireachtas, 2017).

Another important goal of the scheme is to reduce the workload on primary care providers by improving GPs' access to diagnostic services. The GPACD scheme has been shown to reduce referrals to emergency departments, acute medical units and outpatient clinics (Stanley et al., 2025). The scheme has been expanded to include a wide range of services available within primary care settings, enabling more investigations and treatments to be managed closer to patients' homes, rather than at the hospital (HSE, 2025a). Together, this scheme aims to support a more efficient, patient-centred healthcare system with better outcomes across multiple levels of care.

2. Purpose

The purpose of this research project is to gain a holistic understanding of the impact of the GPACD scheme on radiology diagnostics by recording and analysing the perspectives of a diverse range of stakeholders, including patients, GPs, specialists, consultants and representatives involved in health policy development and advocacy.

This comprehensive insight aims to evaluate the programme's effectiveness, identify benefits and challenges experienced across the healthcare system, and assess its potential for expansion into other areas of healthcare. This report also seeks to assess if GPACD referrals have been facilitating timely access to imaging services that support accurate diagnosis and effective treatment planning.

By integrating multiple viewpoints, the research seeks to inform evidence-based recommendations that support improved patient outcomes, streamlined diagnostic pathways, and sustainable healthcare delivery.

3. Methodology

The data collection for this research project employed a combination of qualitative and quantitative methods in order to achieve a comprehensive understanding of the GPACD scheme.

A brief review of relevant online material was conducted to contextualize the research and inform the study design. This involved systematically searching official websites, government reports, and publications from health authorities such as the HSE, the DOH and the Oireachtas. Key documents related to the GPACD scheme, including policy frameworks, programme evaluations, and statistical data on diagnostic access and waiting times, were examined. Additionally, materials from patient advocacy groups and professional healthcare organisations were reviewed to capture a broad spectrum of perspectives. This online review provided essential background information, helped identify gaps in existing knowledge, and guided the development of interview guides and survey instruments used in the study.

Quantitative data collection complemented the literature review. A brief online survey consisting of a mix of multiple-choice and open-ended questions was disseminated to GPs. This survey assessed the accessibility of diagnostic testing for conditions covered by the GPACD scheme, the speed of referrals for imaging tests, and the programme's effect on referral times.

Qualitative data were gathered through one-to-one interviews with a wide range of stakeholders: patients, family carers, representatives from patients' associations and advocacy groups. These interviews explored their experiences with waiting times in both public and private healthcare settings, their interactions with medical professionals throughout the diagnostic journey, and their outcomes in terms of diagnosis and treatment. These discussions provided insights into the broader challenges faced by patient groups and their priorities regarding service provision.

Additional Interviews were conducted with healthcare providers working in both public and private sectors, including GPs, hospital consultants, and doctors in acute care. These interviews explored access to resources, diagnostic pathways for public and private patients, patterns of hospital presentations, waiting list experiences, and the perceived impact of the GPACD scheme on reducing waiting times and avoiding/stalling disease progression.

Qualitative data were analysed using thematic analysis, involving systematic coding of interview transcripts to identify and organize key patterns and themes. Transcripts from interviews and qualitative survey responses were

read thoroughly, and significant ideas were coded and grouped into broader themes reflecting stakeholders' experiences and perceptions of the scheme. This approach both enabled exploration of emerging insights and focused analysis based on the research questions, ensuring a clear and nuanced understanding of the data.

4. Literature Review

4.1 Sláintecare: Advancing Universal Health Coverage

Low service capacity has been highlighted repeatedly as a weakness in the Irish healthcare system (DOH, 2018; Keegan et al., 2019). Launched in 2017, Sláintecare is an initiative aiming to reform Ireland's healthcare system from a two-tiered (public/private) system to universal healthcare (Oireachtas, 2017). Moving towards universal health coverage requires movement to widen healthcare along multiple axes: extension to the non-covered, reduction in direct cost and inclusion of other services (World Health Organization, 2010).

Key Sláintecare recommendations focus on making healthcare better and easier to access. This includes improving services like family doctors, mental health support, social care, and dental care. It also aims to reduce or remove fees for healthcare, increase funding to support the system, and update laws to help these changes happen. Outlined in Sláintecare are potential solutions to waiting list management, such as eHealth, bed limits, and single integrated hospital waiting list management systems. However, as noted by the Health Research Board, there are some challenges around the language used in the Sláintecare report, including a lack of clarity as to how universality is defined and how the principle will be applied (Connolly & Wren, 2019).

Sláintecare is a long-term initiative aiming to transform Ireland's health and social care system by improving access, enhancing quality, and promoting integrated, patient-centred care over the three-year period (Government of Ireland, 2021, 2022). Advancement of the GPACD scheme was recently covered under the Path to Universal Healthcare: Sláintecare & Programme for Government 2025+, in which the GPACD scheme is listed as a deliverable under the Enhanced Community Care Programme and is clearly defined as supporting general practice (Government of Ireland, 2022).

In particular, Sláintecare sets out maximum wait times targets of no more than 12 weeks for inpatient/day case procedures and gastrointestinal endoscopies, and no more than 10 weeks for new outpatient appointments. The annual Waiting List Action Plans aim to improve safe and timely access to healthcare and sets out to reduce waiting lists based on annual targets (DOH, 2023, 2024, 2025).

4.2 Public Waiting Lists

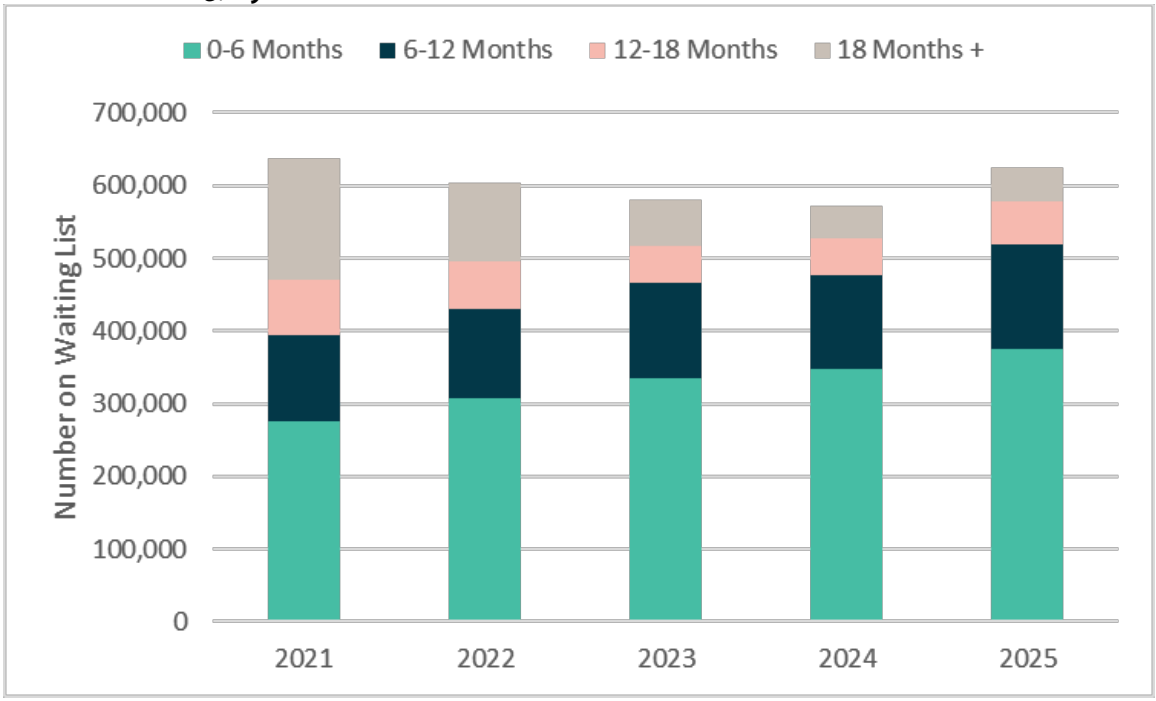
National Treatment Purchase Fund

The National Treatment Purchase Fund (NTPF) is a statutory body established in 2004 with a broad aim of helping to address waiting times for healthcare appointments in Ireland (NTPF, 2023). The NTPF's responsibilities include collecting, validating, and publishing data in relation to public hospital waitlists. Data on inpatient/day case, outpatient, and planned procedures waitlist numbers are published monthly on the NTPF website, organised by hospital group and specialty and disaggregated by wait times. In addition, other data collated by the NTPF is occasionally made available through other sources, such as data on waitlist numbers for specific procedures cited on the Oireachtas website (Oireachtas, 2023e). Notably, the NTPF does not disaggregate data by county, community health organisation or regional area, making population level comparisons with national census data difficult. A monthly summary of these aggregated data is also available on the HSE website.

Prior to the inception of the GPACD scheme many public patients would have been sent to obtain diagnostic scans at public hospitals. However, NTPF data are not disaggregated in a way which allows for a direct assessment of the impact of the scheme on public hospital waiting lists.

In a study looking at NTPF data from 2014 to 2019, Social Justice Ireland (SJI) found that the number of people on outpatient waiting lists increased drastically, with approximately 536,410 patients waiting at the end of November 2019 (SJI, 2020). Further analysis of these 2019 data indicates that waiting times were distributed evenly across age groups (SJI, 2020). In 2020 and 2021, long waiting times for patients were exacerbated by the reduced access to health care services during the COVID-19 pandemic. In November of each year since 2021, over 570,000 patients were waiting for public hospital services (Figure 1).

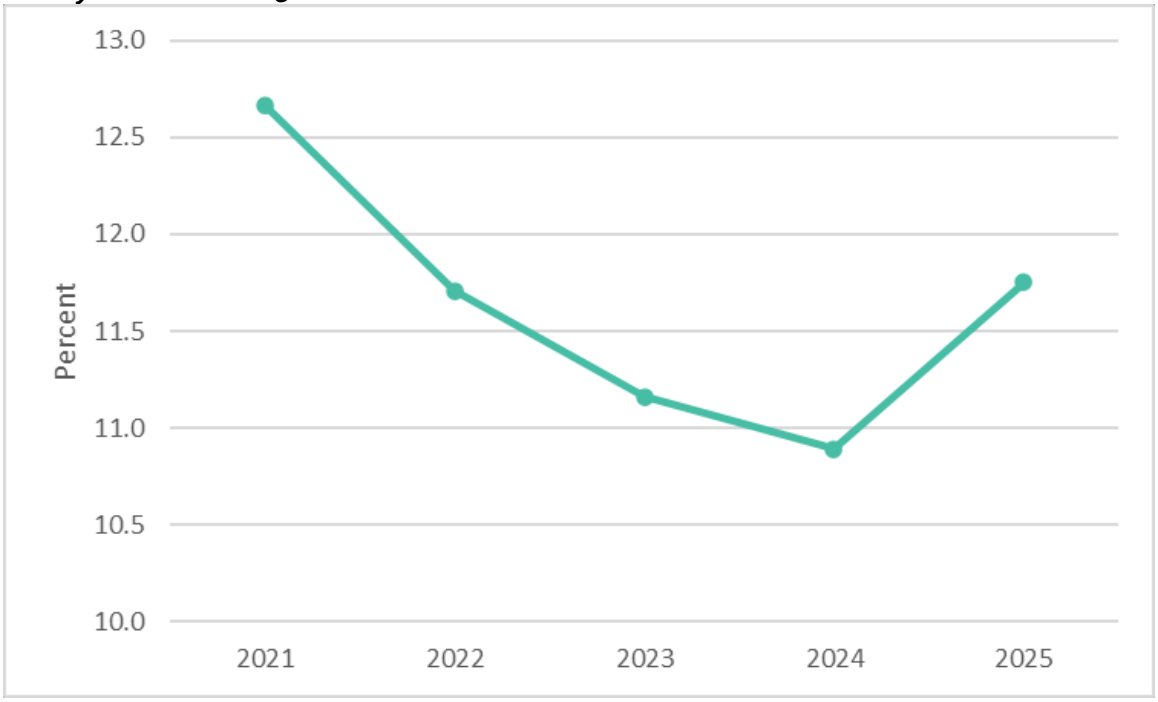
Figure 1. Number of Patients on Public Hospital Waiting Lists in November of Each Year: 2021-2025, by wait time



(Source: NTPF, 2025)

Although raw figures from the NTPF indicate that outpatient waiting list numbers are increasing, the proportion of the population on waiting lists decreased in the first few years of the GPACD scheme (Figure 2). Between 2021 and 2024, the data shows a consistent decline, with percentage decreases of 5.3% in 2022, 3.8% in 2023, and 1.3% in 2024. This indicates a gradual slowing in the rate of decline over these years. However, in 2025, there is a notable reversal, with a large increase of 9.0%.

Figure 2. Proportion of Population on Outpatient Waiting Lists (%) in November of each year: 2021-2025.



(Source: NTPF, 2025)

A national report from the HSE highlights that although weighted average wait times have been declining since 2023, each year has been consistently higher than the key performance indicator target figure (HSE, 2025b). In addition, across all the health regional areas nearly one in three outpatients are waiting more than 10 weeks to access services, indicating that Sláintecare targets are not being met (HSE, 2025b).

These delays may be due to a variety of reasons, including high demand, limited hospital capacity and insufficient staffing levels (IHCA, 2024; Sicari & Sutherland, 2023), as well as diagnostic imaging tests. However, due to the way that the data are disseminated by the NTPF, it is not possible to look closer and determine if the reductions in outpatient waiting times observed between 2021 and 2024 are caused by the GPACD.

Waiting for Diagnostic Scans

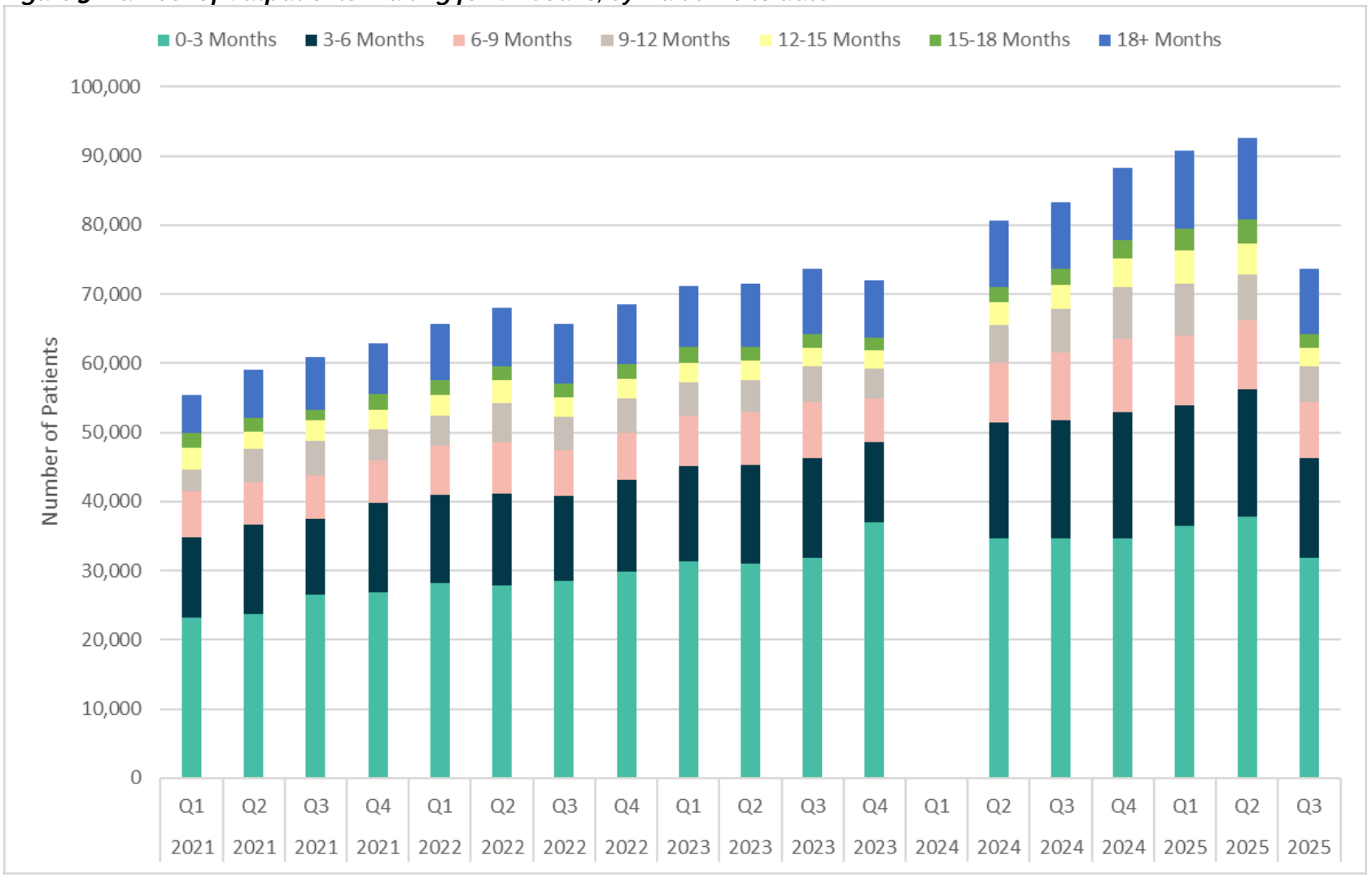
Before the GPACD scheme was introduced, wait times for thoracic CT scans in the public system could be as long as 180 days, whereas private insurance holders typically accessed these scans within just one day (O'Riordan et al., 2013). O'Riordan and colleagues (2013) also found that public patients faced waits of up to 24 weeks for DEXA scans, while private patients could receive a scan within a week of referral. At that time MRI wait times for public patients

ranged widely from 6 days to 72 weeks, averaging around 22 weeks. For X-rays, private patients were usually accommodated within a day to about three and a half days, while public patients experienced wait times of up to three weeks.

Concerns about waiting times have been the topic of discussion at the Dáil Éireann during parliamentary questions. As such, the Oireachtas have published reports containing a breakdown of imaging scans according to the NTPF (Oireachtas, 2023a, 2023c, 2023b, 2023d, 2024a). When compiled, the data in these reports demonstrate both increasing wait times and increasing number of outpatient numbers for both CT (Figure 3) and MRI scans (Figure 4). These figures provide detail to the trends seen in overall outpatient figures and the temporal fluctuations in patient waiting. Over the course of the last four years, there has been steady growth, with a notable acceleration in 2024, indicating increased pressures. The marked decrease in Q3 of 2025 for both CT and MRI scans may be the result of effective interventions or reporting changes. Further investigation and additional data are necessary to determine if the decline will continue.

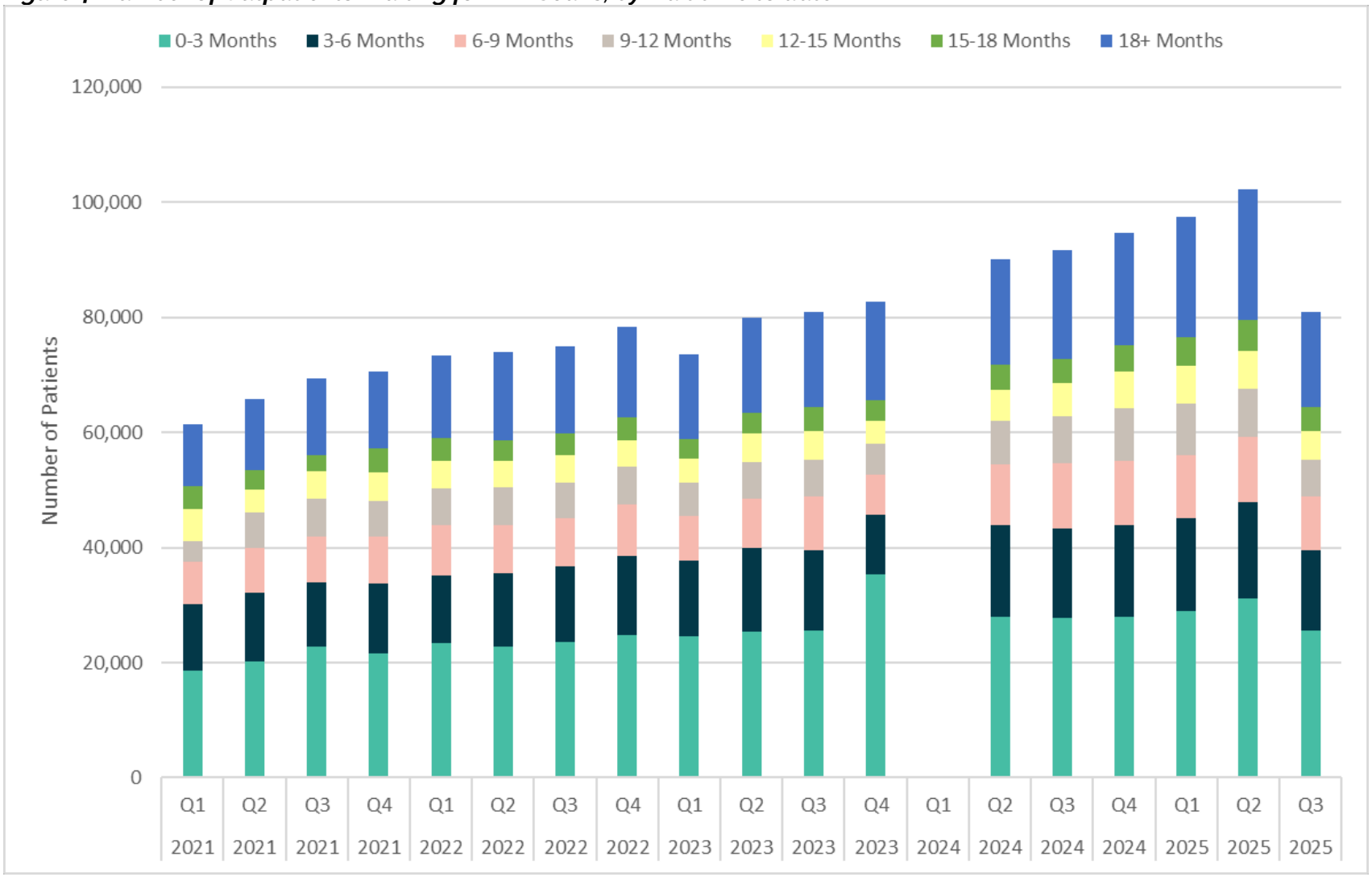
The 2022 Sláintecare Progress Report states that 85% of patients referred via the GPACD scheme are accessing their scans within four weeks (Government of Ireland, 2022). A recently published study conducted around the same time as the Sláintecare Progress Report looked directly into the waiting times of primary care patients seeking diagnostic imaging scans (O'Callaghan et al., 2024). Based on data sampled from 11 GPs, O'Callaghan and colleagues (2024) found that wait times from 2019-2021 increased in 81 instances for patients seeking diagnostic scans, with the median referral time going from 9 to 15 days (O'Callaghan et al., 2024). This is contrary to what would be expected based on the GPACD being put in place in early 2021, as the GPACD scheme aimed to reduce wait times.

Figure 3. Number of Outpatients Waiting for CT Scans, by wait time to date



Note: Data for Q1 2024 are not available.
(Source: Oireachtas, 2023a, 2023c, 2023b, 2023d, 2024a)

Figure 4. Number of Outpatients Waiting for MRI Scans, by wait time to date



Note: Data for Q1 2024 are not available.
(Source: Oireachtas, 2023a, 2023c, 2023b, 2023d, 2024a)

Participating GPs estimated that if the scheme were unavailable, 20% of the patients referred by them for tests through the GPACD scheme would have required urgent hospital assessment. As a result of the GPACD scheme, the actual figure was 4% (O'Callaghan et al., 2024). Participants also highlighted the role of the scheme in improving the quality of care received by their patients, through allowing for quicker diagnosis and thus provision of care as well as shifting care into the community. While some participants stated that the scheme increased their immediate workload, the potential for the scheme to decrease their workload in the long term was noted also (O'Callaghan et al., 2024).

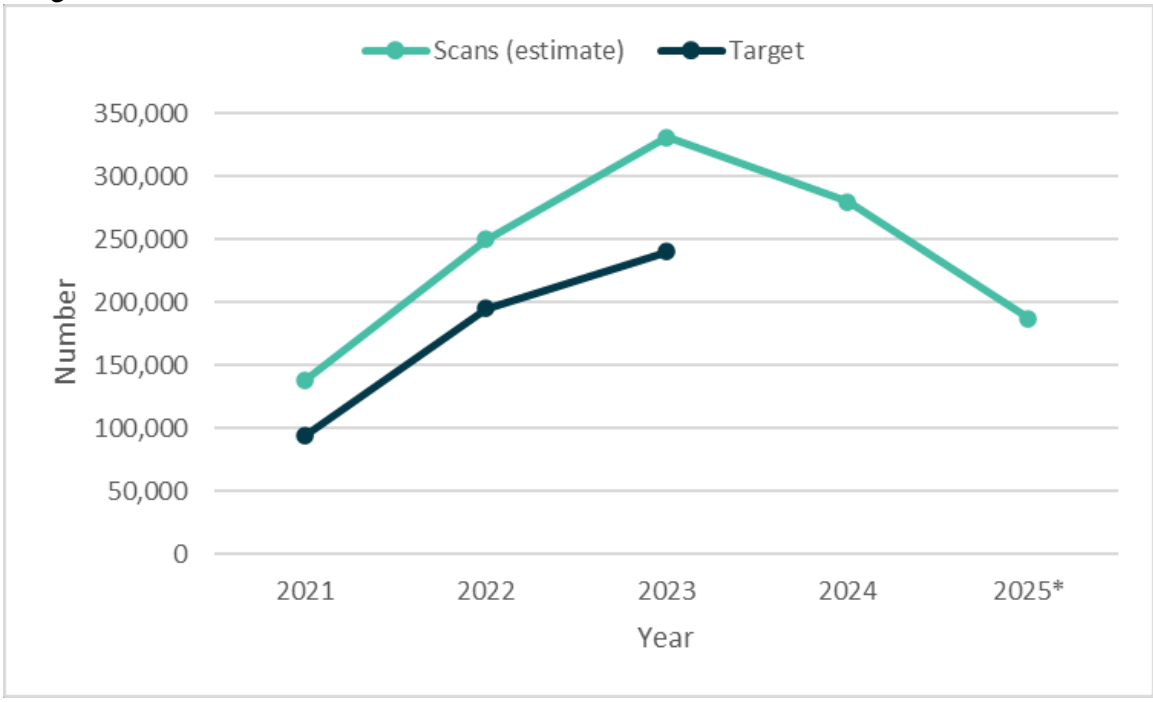
4.3 System Capacity

Volume of Radiology Diagnostic Scans

As shown in Figure 5, the number of scans conducted each year increased substantially from approximately 138,000 in 2021 to approximately 331,000 in 2023, when the number of scans performed annually more than doubled in comparison to the first year. The ongoing trajectory is unclear as the number of scans in 2024 decreased and the data for 2025 are not yet complete (DOH, 2024; Nursing in Practice Ireland, 2024; Oireachtas, 2025). Publicly available data from the DOH indicate that in the first three years, the GPACD scheme was heavily used with over 700,000 diagnostic scans having been completed (DOH, 2024).

In 2024, the HSE raised concerns that the scheme was being overutilised and potentially used inappropriately. In response to those concerns, the HSE produced a quick reference guide for GPs to help them to choose appropriate imaging methods for different clinical conditions (HSE, 2024; Wall, 2024). From the HSE's letter to GPs it is not clear precisely what concerns were raised and by whom. However, the letter focuses on providing guidance on referrals for MRI scans (HSE, 2024). This MRI guidance recommends cautious use of joint imaging, favouring X-rays for older patients with osteoarthritis unless red flags exist, and advises against routine lumbar spine MRIs for acute or non-specific low back pain without red flags, reserving them for specialist cases or persistent symptoms. GPs are also encouraged to use clinical guidelines, such as iRefer, and the Quick Reference Guide to select the most appropriate MRI exams, avoiding unnecessary or repeated imaging within a year unless clinically justified (HSE, 2024).

Figure 5. GPACD Diagnostic Imaging Scans Conducted by Year (2021-September 2025)



* Estimate from January to September 2025.
(DOH, 2024; Nursing in Practice Ireland, 2024)

Variations in Eligibility by Imaging Type

Currently, the GPACD scheme covers services such as X-ray, CT, MRI, and DEXA scans and is available to all adult patients aged 16 years and over throughout Ireland. These services are delivered through a network of approved private providers, including Affidea, Alliance Medical, Bon Secours (Tralee), Medica, Mobile Medical, Complete DEXA Solutions, Beaumont Private, and UPMC Whitfield (HSE, 2025a). This broad availability ensures that GPs can refer any adult patient for these essential diagnostic tests.

In contrast, access to ultrasound services through the GPACD scheme is more restricted. Access is available only to adult patients aged 16 and over who hold a medical card, GP visit card, or Health Amendment Act card. Ultrasound services are provided via a select group of private providers, including Scan Clinic, Medica, Alliance Medical, Affidea, Bon Secours (Tralee), and Beaumont Private (HSE, 2025a). These eligibility criteria reflect a targeted approach to ultrasound referrals, prioritising patients with specific healthcare entitlements while still leveraging private providers to deliver these diagnostic services efficiently. However, limiting the scheme to patients is problematic as establishing eligibility can be a time-consuming and complicated task. In particular, it has been argued that the means test associated with an

application for a medical card is an overly onerous process in Ireland, when compared to similar schemes in other countries (Stan, 2015).

Regional Variation in Access
The GPACD has been rolled out on a phased basis with variations in access noted for specific regions, scan types and diagnostic tests since 2021 (HSE, 2025a). Historically, there exist inconsistencies in the provision of GPACD services across different geographical regions. For example, in the first few years of the scheme patients in Cavan and Monaghan had to travel outside of their counties in order to access X-Rays, CT, DEXA, and MRI scans. In addition, those living in Mayo, Longford, and Wicklow could not access any of the GPACD diagnostic scans within their own counties. On the other hand, patients in Dublin, Kildare, Galway, and Cork had at least one provider–and in some cases multiple providers–of each scan available within their county. These geographical gaps in service provision may impede some patients' ability to avail of the GPACD scheme, such as those who cannot drive (for example, due to disability), have caring responsibilities, or are on lower incomes.

Financial Investments
In tandem with increased referral and uptake, the scheme has seen substantial investment from the DOH. Initially, the annual GPACD budget was €25 million in 2021, increased to €46.8 million in 2023 and again to €47.9 million in 2024 (DOH, 2024). Unfortunately, at the time of publication no data were publicly available that would allow for a differentiation in investment by diagnostic scan or test type.

This persistent increase in funding is reflected by a rapid scaling up of community diagnostic capacity in the private sector, thus showing the government's financial support for improving access to diagnostic imaging for patients outside of public hospitals. However, in spite of large financial investments, there are limits to who can access the scheme. For example, access to ultrasounds is restricted (as described above).

5. Survey

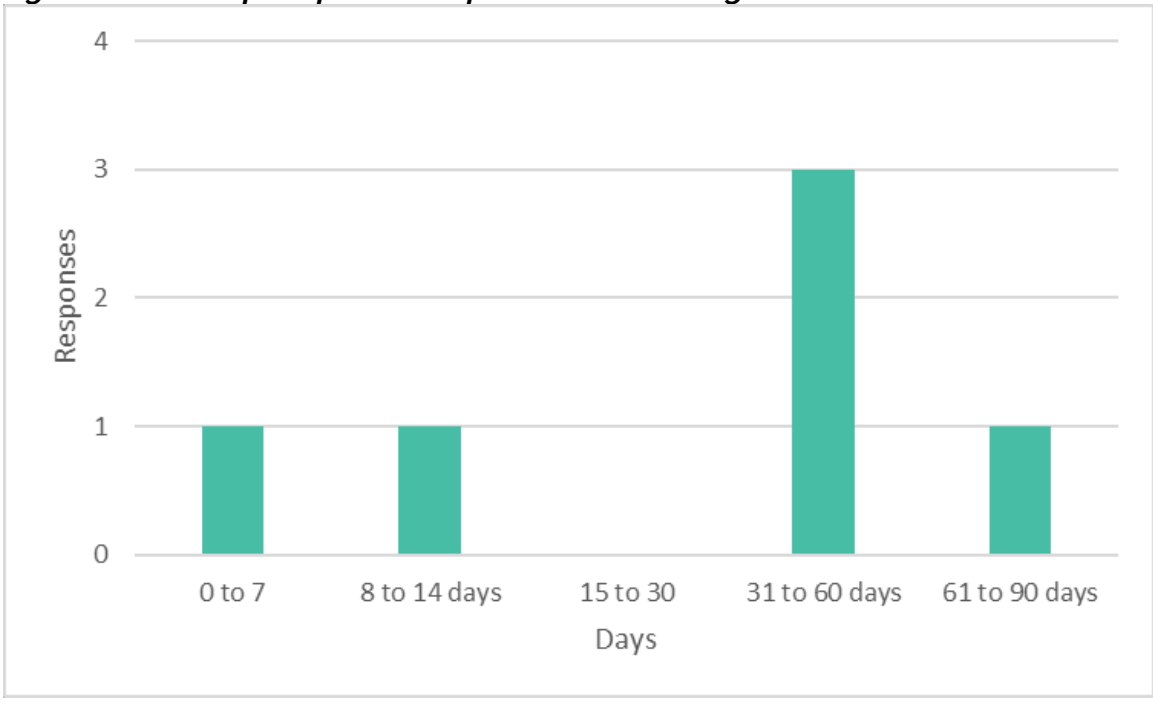
5.1 Participant Background

Six participants responded to the survey in March 2024. All survey participants were GPs who had spent at least five or more years working in primary care and were intimately familiar with the GPACD scheme. GPs reported actively referring patients to obtain scans under the GPACD scheme: ultrasounds (N=6), MRI scans (N=6), CT scans (N=5), DEXA scans (N=4) and x-rays (N=4). Referrals were typically issued using Healthlink (N=6), with one GP also using the post.

5.2 Wait Time for Results

From the point of referral, GPs most commonly reported waiting one to two months to receive the scan results (Figure 6).

Figure 6. Time elapsed from the referral until receiving the scan results.



5.3 Scan Results

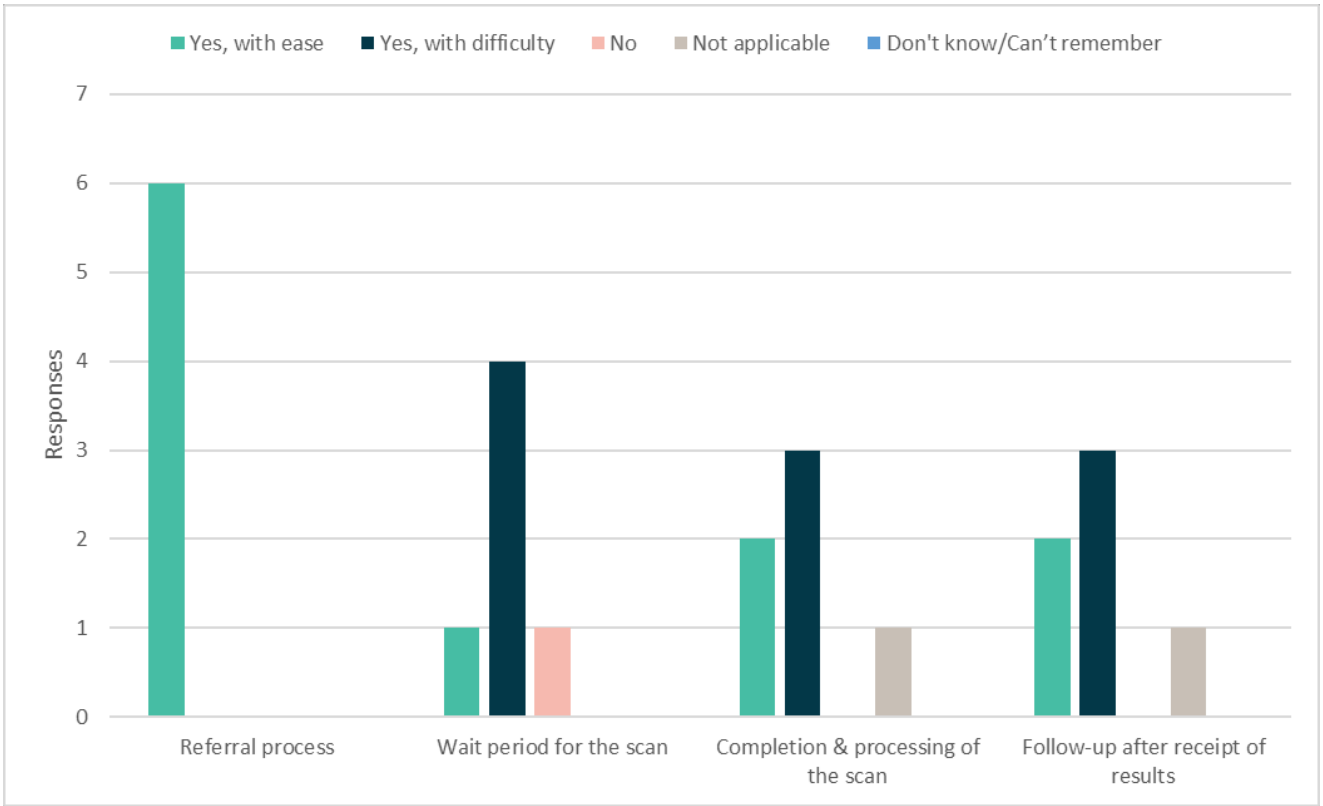
GPs reported that the results of scans were received primarily from Healthlink (N=6), but also by email (N=2) and by post (N=1). In a comment, one GP stated that interpreting scan reports can be challenging and that GPs should be provided with support. In addition, they stated that guidelines regarding recommendations for specialist referral would be appreciated.

5.4 Communication with Private Providers

Pathways

Overall, survey respondents stated that communication with private providers was mostly smooth at the point of referral, with difficulties arising in the later stages, namely the wait period and scan processing (Figure 7).

Figure 7. Communication with Private Providers During Different Stages



Influences on Referral Patterns

Qualitative responses revealed a clear preference for specific private providers, primarily due to better communication, greater accessibility, and shorter waiting times. The less favoured providers were described as difficult to contact throughout the process and less helpful, particularly in managing vulnerable patients such as those with language barriers. GPs raised additional concerns around navigating and accessing some services (e.g. ultrasound) offered by specific providers on the GPACD scheme; thus, ultimately complicating perceptions of accessibility and GPs' satisfaction.

GPs and their staff seek solutions to the challenges faced when interacting with private diagnostic imaging providers. Collaborative efforts to improve communication and patient navigation had been successful with certain providers, but not with the less favoured ones. In situations where private service providers were seen as being inefficient and unresponsive to collaborative solutions, GPs would refer patients to hospitals instead.

Overall, the preferred providers were viewed as being more reliable and supportive, while the others struggled with communication and service quality.

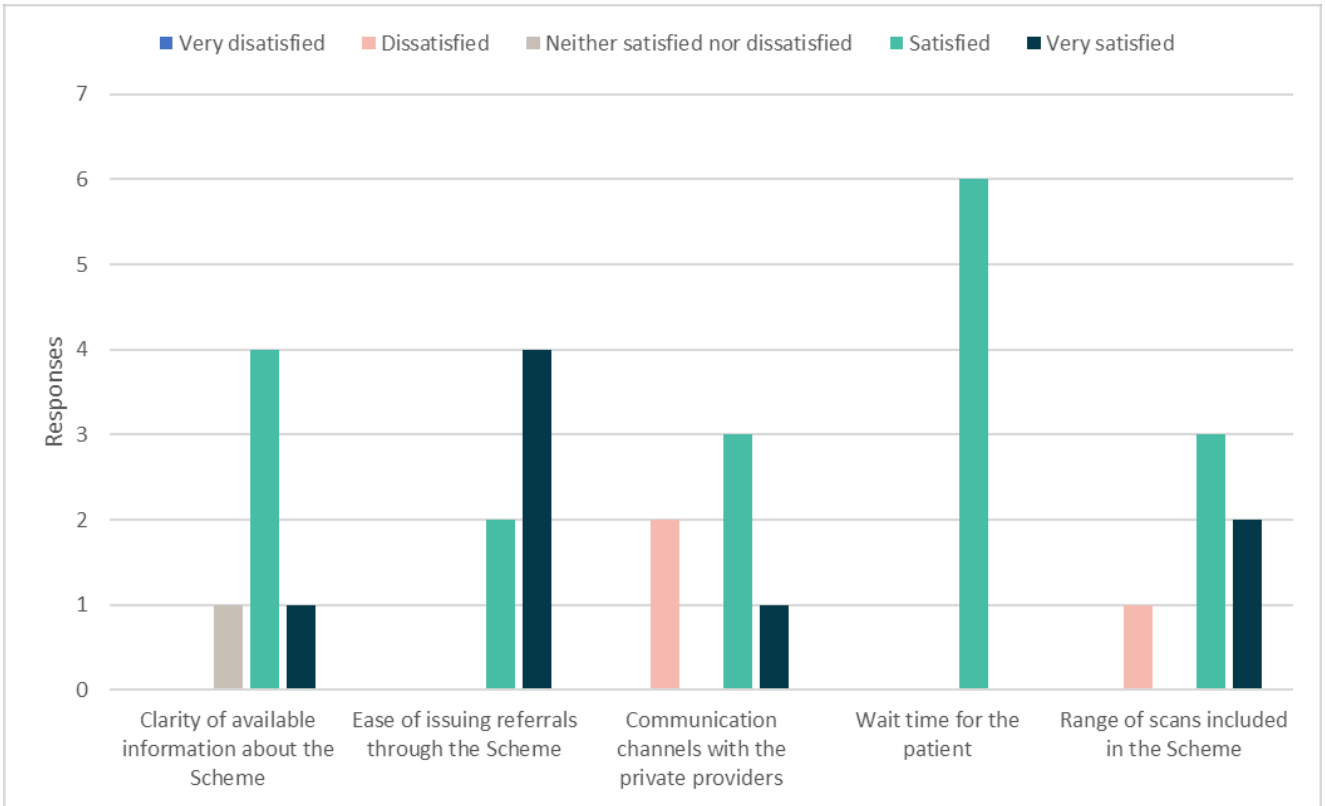
5.5 Perceptions of the Scheme

Satisfaction with the scheme was generally high across most categories. All GPs stated that they were satisfied with wait times. High levels of satisfaction were also noted regarding issuing referrals through the scheme and clarity of available information about the scheme. Some dissatisfaction was noted in relation to the communication channels and the range of scans available (Figure 8).

Limited Scan Options
Some respondents included qualitative responses in which they explained that the scheme offered limited scan options for them, which, while economically understandable, created challenges when follow-up scans recommended by radiologists are not covered. They explained that this often forced referrals to hospital specialists, as direct hospital access to these scans was also not available.

Efficient Access to Diagnostic Scans
Despite these limitations, the scheme was valued for its efficiency, particularly for MRI scans, which are completed quickly and significantly aid patient management.

Figure 8. Satisfaction with Aspects of the Scheme



Linguistic Barriers for Patients

However, respondents went on to explain that many patients face language, literacy, and digital access barriers. Private scan services are generally provided only in English, requiring some patients to bring interpreters. One provider has shown some flexibility by assisting with translated safety questionnaires, while another struggles with communication, frequently sending unreachable or incomprehensible messages to patients. This creates inequities, making access difficult for non-English speakers and those with limited literacy or digital skills.

Improved Quality of Referrals

The availability of relevant imaging results was reported to improve the quality of referrals. While the scheme likely has little impact on emergency referrals, it may have shifted referral patterns within specialties, with some increasing (e.g. spinal surgery due to more lumbar MRIs) and others decreasing (e.g. respiratory, due to access to CT scans).

Improvements in Cancer Detection and Outpatient Waiting

Some GPs chose to elaborate further on how the scheme has impacted other aspects of their work. One GP, working in an area of high deprivation with a large number of medical card patients, noted that there was a higher

incidence of cancer and historically late diagnoses due to low incomes limiting out of pocket payments. They stated that since the introduction of the GPACD scheme, cancer detection has improved significantly, and outpatient department wait times have shortened by enabling GPs to exclude certain conditions themselves.

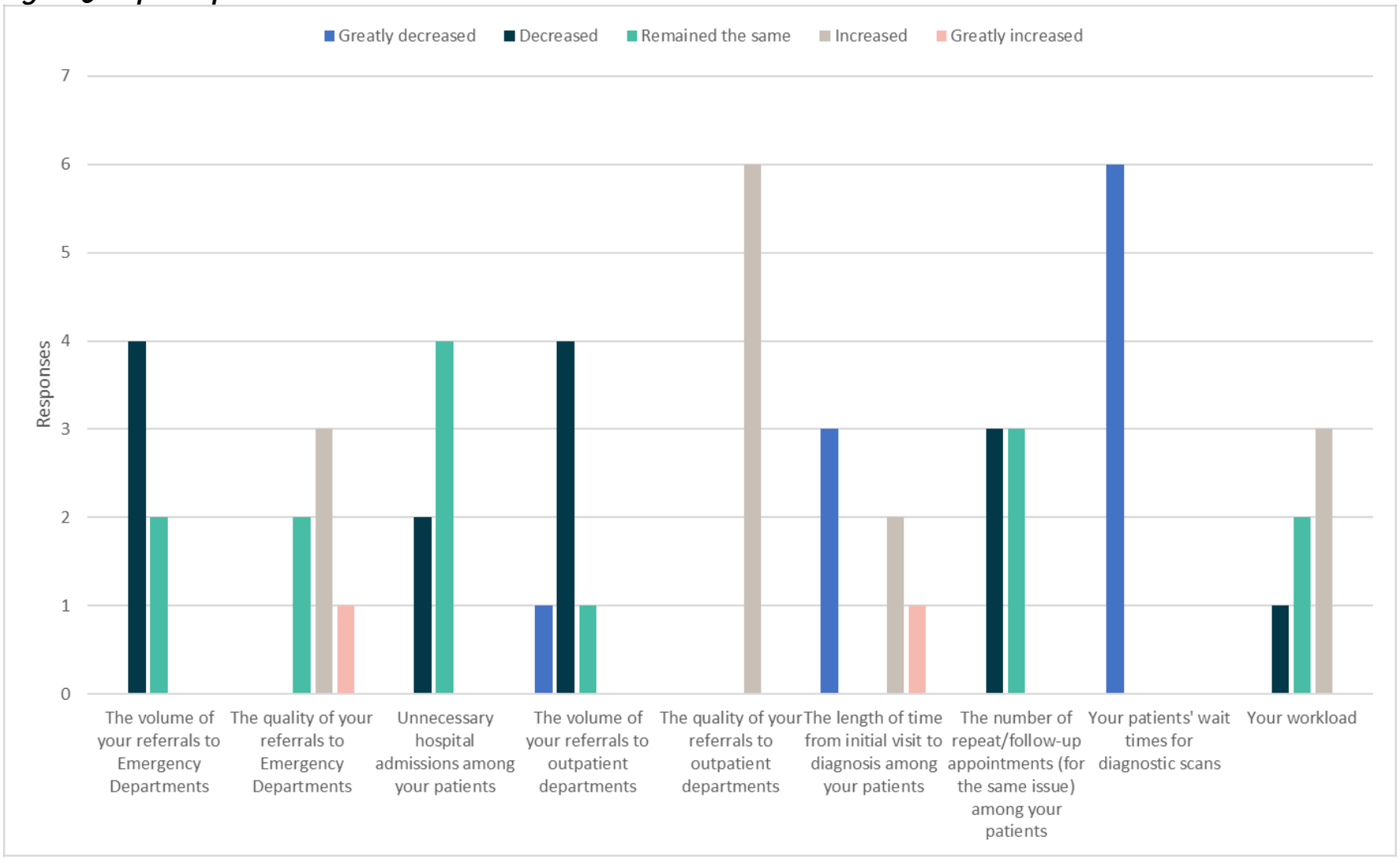
GP Workload

When queried about the impact of the scheme on their work on various aspects of referral patterns, patient outcomes and provider workload, responses were generally favourable (Figure 9). Referral volumes to both emergency and outpatient departments have decreased, while the quality of referrals (e.g. to outpatient departments) have improved. Unnecessary hospital admissions have remained stable or decreased, and patient wait times for diagnostic scans have greatly reduced. Despite these positive changes, overall workload tends to be increasing, even with the decline in referral numbers.

GPs explained that the scheme has increased workload for primary clinicians, as they must interpret often complex diagnostic results. However, it is not used to avoid emergency department referrals but rather to support outpatient management, primary care, and physiotherapy referrals. GPs felt that the scheme is highly beneficial for patients, significantly reducing referrals to outpatient departments by enabling quicker access to scans, which allows for more appropriate triaging and often eliminates the need for additional visits. For example, pelvic scans could be obtained within a month, compared to previous waits of many months for appointments and results.

Lastly, the scheme has also increased administrative workload related to follow-up on scans. Additionally, hospital services sometimes direct patients or request GPs to arrange scans through this scheme because it offers a faster alternative to hospital-based pathways. This further increases the workload faced by primary care providers.

Figure 9. Impact of the Scheme on GPs' work



6. Interviews

Sixteen interviews with GPs, specialist consultants, radiologists, and patients revealed a variety of viewpoints on the GPACD scheme and its impact. Participants included 4 GPs, 1 endocrinologist, 2 neurologists, 3 radiologists, 4 patients, and 2 NGO representatives. Respondent clinicians worked in both public a private settings. In addition, some patient advocates spoke from the perspective of their NGOs as well as from their personal experiences as patients.

6.1 Positive Impacts on Community and Patient Care

Timely Scans and Reduced Wait Times
All stakeholders reported that under the GPACD scheme, many patients were indeed receiving their scans in a matter of weeks, thus potentially reducing the wait times for some procedures. When mentioned, delays were attributed to issues associated with communication and accessibility of the facility.

Some private scan providers were very responsive to the needs of primary care services and have been known to expedite urgent requests. One GP said, “If I put something as urgent, they do it very quickly. It's fantastic. It's [a] really, really good service.”

Fewer Emergency Room and Hospital Visits
Anecdotal evidence from primary care providers, patients and patient advocates indicates that there may be a reduction in emergency department hospital admissions as a result of the GPACD scheme. In praise of the scheme, one GP stated:

> “I haven't actually systematically counted it. But I'm conscious of referring a lot less to hospital. …The group that I've almost completely stopped referring, are all those musculoskeletal patients with back pain. So a lot of people, reviewing the outcomes of a programme like this might say, 'Oh, but look, only 10% of the scans were abnormal. That's a terrible waste of money. Imagine doing all those scans and 90% of them were fine.' The reality is that a negative scan is every bit as important as a positive one, as an abnormal one. Because it saves so much in terms of referrals and outpatient time. And, you know, healthcare system utilization of patients.”

Some GPs argued that negative scans still save outpatient time and resources by avoiding unnecessary hospital visits.

6.2 Public vs Private Patients: Access, Equity, Quality, and Financial Implications

In interviews, there was found to be a general belief among healthcare providers that the GPACD scheme aims to provide equitable access for public and private patients. GPs and patients were very much in support of the GPACD scheme, saying that it improved access for public patients.

Both GPs and specialist consultants also highlighted that, due to limited diagnostic resources, private patients were potentially being deprioritised. However, it was not possible to verify this as private patients did not perceive a decrease in access to diagnostic tests.

Additionally, healthcare providers noted that public patients continue to experience longer wait times and variability in quality, while private patients often have the advantage of accessing expedited services or traveling to facilities with more advanced scanning equipment.

Healthcare providers also seemed to see private patients as having other options (e.g. private clinics or faster access through insurance), thus reducing the urgency of ensuring their inclusion in public diagnostic schemes.

> "So the private thing, I think there's probably plenty of access to private patients, you know, they just go somewhere else… They just go to Dublin. You know, I don't think it's been a real problem for private patients."

6.3 Impact on Workflow: Higher Usage, More Referrals

Incidental Findings, Increased Referrals and Increased Workload for Hospital Staff

Clinicians from a variety of backgrounds acknowledge there is a paradox of diagnosis that exists: the idea that medical tests and scans aim to detect illness early and improve health outcomes, but that they can sometimes lead to unintended negative consequences (such as misdiagnosis, or increased patient anxiety). However, interviews with GPs and radiologists showed different perspectives on this issue. GPs described their role in the GPACD scheme as supporting patients in their journeys, alleviating some of the stress associated with pain and illness and reducing long public waiting lists. However, one radiologist stated that "[the GPACD scheme] definitely creates some additional referrals that wouldn't be there if the scans weren't done". They continued to say that they "do not see the other side", they "don't see the patients that potentially haven't been referred because they had a scan which was reported as normal."

During interviews, radiologists highlighted that many scans conducted through the GPACD scheme are deemed unnecessary or are not tailored to the clinical question. This results in inappropriate referrals. Radiologists raise concerns about the overuse of GPACD scans, which may not always yield clinically useful information.

During one interview, a radiologist mentioned that GPs are referring many patients for diagnostic scans which are unnecessary. There are GP clinical guidelines in place, however, radiologists feel that GPs are not always following guidelines and are providing superfluous referrals which result in unnecessary consultations, taking up outpatient slots that could be used for more urgent cases.

In addition, diagnostic tests often discover incidental findings that lead to additional referrals, even when they are clinically insignificant or over-reported. One radiologist provided an example of an inappropriate referral from a GP which generated an additional referral:

> "So GPs, let's say, have a blood test and they have abnormal thyroid function. For example, someone is hypothyroid and they order ultrasound, which normally we would not order, because it wouldn't be a part of the routine workup. And then this ultrasound is reported that this showed some incidental finding, for example, of a thyroid nodule. And this patient is referred to us. We have to repeat our own scan to reevaluate that nodule, you know."

It was also mentioned by some radiologists that GPs might not be best placed to choose what type of scan is necessary. One radiologist stated:

> "I think a lot of the time they're being accessed inappropriately, or the inappropriate, the wrong scan, is being done. So, I think there's a lot of waste in it."

Resource Gaps for Public Services

There are clear access inequalities for patients accessing public scans in comparison with those accessing private scans. One specialist consultant highlighted the issue in an interview:

> "But in our hospital anyway, the waiting list for MRI is very long for scans that we order in the hospitals. So, if I order an MRI on one of my patients, it could be two years before they get an appointment in the hospital."

Hospitals lack sufficient resources (e.g. scanners, radiographers and radiologists) to handle increased follow-up demand from GPACD referrals. One radiologist explained that they are unable to refer patients for

neurosurgery without a scan, but hospital scans can take two to three months to be conducted. This leads to serious delays in treatment. Since patients can deteriorate quickly, this delay is risky. They contrasted this example with patients accessing scans "within a month" through the GPACD scheme. However, they stated that the GPACD scans are "not necessarily of a great quality". The combination of long waits, high demand, and inconsistent scan quality adds to their frustration.

Fixing one Bottleneck, Creating Another
Radiologists and specialist consultants have raised multiple concerns about the GPACD scheme shifting patient waitlists to another stage of the patient pathway, while potentially convoluting the diagnostic pathways and creating an additional burden on public hospital systems. One interviewee stated:

> "It's a fallacy that GPs can see, or they'll get a quicker diagnosis because they're going to the hospital with a scan. Give me a break, like most of them didn't need to go in there in the first place."

While explaining how the patient pathway was being negatively affected, another clinician said that patients who have accessed scans through the GPACD scheme "push back all the other patients, and everybody else is waiting. So it's just got a massive knock-on [effect]".

System Strain and the Ripple Effect on Primary Care
The challenges within the healthcare system often create unintended consequences for both specialists and primary care providers. One radiologist highlighted how delays in hospital access for imaging scans are shifting burdens onto primary care services, as well as affecting care quality and collaboration:

> "But I think where the problem arises is that, through nobody's fault, it's now being leveraged by specialists for imaging to be done, for specialist questions, because we don't have the timely access that we need in the hospital system. So I think there are all sorts of issues with that, in terms of the quality of the reporting, being able to discuss cases at multidisciplinary meetings, having interval imaging, etc. But it's also sort of unfair on our colleagues in primary care to land the problem back in their door."

6.4 Navigating the Scheme as a Patient

A Seemingly Complex and Opaque System
There appear to be no clear instructions from the HSE for patients on the GPACD scheme or how it is to be navigated. However, information gathered through interviews indicates that patients referred on to the scheme are

expected to complete a separate questionnaire and download an application specific to the private provider. All instructions are provided in English by the private providers. In addition, scanning services may not be located in an area which is familiar to the patient.

For those who have recently arrived in Ireland or are not fluent in English, this system appears to be difficult to navigate and varies depending on the geographic location and the specific systems of the private scan provider. GPs described seeing patients unfamiliar with the healthcare system often struggling with tasks like completing forms, understanding appointment instructions, or navigating transportation.

Insufficient Access to Interpreter Services
GPs have observed instances where non-English-speaking patients missed appointments due to communication failures. They stated that this has led to unfair outcomes, such as being excluded from future referrals under the scheme.

Struggles to navigate the system were demonstrated by incomplete paperwork and missed follow-up appointments for scans. Primary care providers referring patients expressed doubt about the adequacy of efforts by private scan providers to make contact with those patients with limited English.

It has been suggested by GPs that private scan providers often do not offer interpreters, making it challenging for non-English-speaking patients to complete safety questionnaires, understand instructions (e.g. for MRIs or ultrasounds), or schedule and attend appointments. In interviews, clinicians report relying on family members, friends, or online tools for linguistic support (e.g. translation apps). In some cases, they found these to be viable options in the absence of trained interpreters, however they acknowledge that there is a compromise being made regarding patient confidentiality and accuracy.

One GP explained that they and other GPs in their practice have noticed that service provision under the GPACD scheme does not include access to interpreters or translated documents, which in the early days of the scheme resulted in their patients not accessing the requested scans. Therefore, they put structures in place in their general practice to reduce this barrier to accessing the GPACD scheme: using interpreters to translate the questionnaire and send it to the private provider, emailing completed questionnaires to the private provider and supporting appointment scheduling with the private provider. Staff typically ensured a family member who spoke good English was informed about expectations and logistics, often including their phone number in referrals to avoid confusion. This is particularly important for scans like MRIs or ultrasounds that involve specific

instructions (e.g. “like come with a full bladder and don't pee beforehand”) where clear communication is essential, yet none of the scan services provide interpreters or translated materials to patients.

Gaps in Technology Access
Accessing appointment details or completing forms often requires smartphones, email, or internet connectivity, which creates barriers for patients who lack these resources or the digital literacy to use them effectively. Clinicians noted that these barriers disproportionately affected non-English-speaking and socioeconomically disadvantaged groups.

Perceived Service Quality across Providers
Some GPs perceive differences in the quality of services by the different private scan providers in relation to how they handle language and accessibility issues. This perceived variability in patient experience affects GP preferences for particular providers (where possible) and thus referral patterns.

Providers with better practices, such following up effectively regarding missed appointments, are favoured by clinicians working with vulnerable populations. GPs prefer to know that a patient has missed an appointment or been difficult to contact, rather than to hear nothing.

Transportation and Geographic Accessibility
Patients often encounter added difficulties when trying to find and access unfamiliar healthcare locations, especially when language barriers make it hard to understand directions or signage. These challenges are further compounded by limited access to public transport, which can make reaching appointments on time (or at all) particularly stressful and uncertain, especially for those who rely on others for support or translation.

6.5 Poor Communication Patterns Between Frontline Staff and the HSE

Limited Consultation with Healthcare Providers and Missed Opportunities for Feedback
GPs who were interviewed reported that the HSE has provided little to no opportunity for direct consultation on the scheme’s implementation or effectiveness. During interviews, GPs expressed that they were notified that the scheme was being implemented, but were not provided with any opportunity to feed into the scheme’s design. One GP said that they were contacted by HSE more than a year after the scheme had already been implemented. They were pleased by this opportunity to provide feedback,

but expressed that they had yet to see any changes in the overall scheme as a result of the feedback provided.

Radiologists also expressed that they were not consulted by the HSE prior to the start of the scheme or even following the scheme's implementation. Some radiologists who have proactively offered feedback through various professional as well as occupational channels say their input has gone unanswered.

> "But I think if the radiologist report recommends a certain scan, surely we should then be able to get that scan and get it covered for the patients. And I pointed that out to the HSE, but they didn't really respond."

They said that feedback mechanisms were notably absent, despite clinicians' willingness to provide insights on how the scheme functions in practice.

This disregard of their voices has been leading to frustration that their expertise and insights are not being valued. As radiologists highlighted, they are the ones best placed to evaluate the efficacy of the programme because of their position in the patient clinical pathway and their areas of expertise.

Radiologists expressed that there was a disconnect between themselves and the HSE. One radiologist claimed that the HSE was actively avoiding consulting with clinical specialists. They stated that there is a general belief that the HSE avoids consulting clinicians, possibly to sidestep complexity or dissent.

Others, both GPs and radiologists, shared similar views, though less emphatically. In general, clinicians feel that this lack of engagement with service providers undermines the collaborative potential for programme development and improvement.

Inadequate Updates on Operational Changes
GPs were not always informed of changes, such as new private providers joining the scheme or updates to referral pathways. Some GPs only became aware of key developments until well after changes had already been implemented, suggesting poor dissemination of critical information.

Unclear Guidelines
GPs also mentioned that there were guidelines which were promised but never circulated to them. This left them feeling unsure about best practices and expectations under the GPACD scheme.

> "And it said you had to refer, according to the referral guidelines, which will be circulated shortly. And I was wondering, was it ever circulated?"

In particular, radiologists expressed clinical conflicts between GPACD guidelines and specialty specific professional guidance and codes of practice.

> "So I think it's really if people complied with the guidelines, it would definitely help a lot. I suppose, on the radiology side, if these were all vetted appropriately, they'd be all sent back."

Clinicians working in public hospitals suggested that alignment and integration of hospital pathways and resources with the GPACD scheme is needed in order to streamline care.

Since these interviews were conducted, guidelines have subsequently been circulated to GPs. However, it is not clear what factors were taken into consideration when developing them. The integration of guidelines is necessary to ensure that the patient journey through this heterogenous system of blended public and private service provision is smooth and streamlined, avoiding delays, duplication of services, and miscommunication between different parts of the healthcare system.

Absence of Systematic Audits and Unquestioned Contract Renewals
Radiologists expressed concerns around not yet having a comprehensive systematic audit for cost-effectiveness, waiting times, workload impacts on clinicians and clinical outcomes for patients. In addition, both GPs and radiologists felt that private providers needed to be evaluated in some way in order to assess and account for the variations in service provision which are being seen on the ground.

In addition, clinicians express concerns about the programme continuing without evaluation, potentially wasting resources or perpetuating inefficiencies:

> "[Health Information and Quality Authority] (HIQA) should be assessing whether something's appropriate or not, like that is their job, and I'm really surprised that they haven't come down. That is their job. Now I'm not going to ring HIQA because they're just going to show up. I'll be on to you now because you've shown up. And the other thing is, HIQA made a massive big deal to all of us radiologists in the country to report the dose of a CT scan. Right?"

The impression is that contracts with private scan providers appear to be signed and renewed without rigorous evaluation, raising concerns about the long-term financial sustainability of the scheme.

Potential Cost to Taxpayers
Without audits or oversight, there is fear that the scheme may become a significant burden on public finances while failing to deliver equitable, high-quality care to patients. One radiologist highlighted their concerns around the costs of the scheme when discussing the need for it to be thoroughly audited:

> "I think it's worth, you know, calculating [the costs of the scheme], because what worries me is that they'll just keep renewing contracts, and this will keep running, and it's going to cost the taxpayer [a] fortune."

Patients Lack Understanding of the Scheme
Anecdotal evidence suggests patients themselves are often unaware of the scheme and its purpose. During an interview, one patient (who had signed up for the research in their professional role as a patient advocate) became aware of the scheme during their participation in the interview:

> "But yeah, I think I know what you're talking about now. But again, in terms of the scheme, … I wouldn't have known what it was nor was it explained to me, it's just that I was being referred off to [private provider] and it should be within a couple of weeks."

6.6 Challenges in Medical Imaging Services and Governance

Inconsistent Standards of Reporting
During interviews radiologists expressed concerns about reports from private scan providers. Their reports were frequently described as substandard in comparison to those from hospital-based radiologists. A variety of issues were raised including:

- Private scanning facilities are not linked electronically with the National Integrated Medical Imaging System (NIMIS)
- Lack of registration with the Irish Medical Council
- Protocols used for the scan are not specific for the query (e.g. neurodegeneration)
- Lack of training and/or sufficient specialisation (e.g. neuroradiology) for those doing the reporting
- Inability to contact the reporting radiologist
- Ambiguous or overreported findings

Scans conducted under the scheme are reported by private providers without taking into account the complete patient history or clinical context. Patients can also access scans through the provider specific patient portal, in advance of meeting with their GP. Sometimes the "medical speak" included in the scan documentation causes patients to be unnecessarily concerned.

Diagnostic imaging scans conducted under the scheme are reported by private providers. Patients receive the scan findings through online platforms (dependent on provider infrastructure) and meet with their GPs to review the findings and discuss the next steps (e.g. specialist referral). At this point patients then potentially face prolonged anxiety when waiting for specialist consultations, particularly if referred based on unclear findings from GPs or diagnostic centres. This may result in an ambiguity around the report findings, which may be further exacerbated by GPs' and/or patients' inability to adequately interpret the report.

Following the GPACD imaging scan, onward referrals to consultants frequently result in the need to obtain and review the original scans themselves in multidisciplinary team meetings, to verify and interpret the findings reported by private providers. Various issues were mentioned by specialist consultants and radiologists regarding scan quality, including poor quality scans obtained from mobile scanners and the requirement to have images scanned and sent on a disc (which decreases diagnostic quality). Other concerns were raised in relation to the diagnostic reporting being written up by private providers in the absence of a patient's medical history and without appropriate clinical context.

In addition, it was stated that it is critical to ensure that the scans are reported by adequately trained and specialised radiologists to guarantee reliability and accuracy of the information provided. A healthcare provider highlighted this concern by stating, "we just really need to be sure that the person who reports that [scan] has the right training so that the information is reliable".

Of note, it was stated that specialists often disagreed with private scan reports, thus requiring repeat scans in hospitals and undermining the intended efficiency of the scheme.

Lack of Data Integration

Patients can access their scans on a mobile phone but frequently lack physical copies. However, the results of scans conducted under the GPACD scheme are often inaccessible, via the NIMIS (the national Picture Archiving and Communication System), which means that referring GPs and consultant radiologists are unable to see them. Accessing scan results requires a request from the GP, with the scan being provided on a burned disk which then needs to be manually uploaded by staff onto the NIMIS for viewing. This lack of an automated digital solution causes inefficiencies in patient management and reduces the quality of the diagnostic image, further complicating care continuity.

Lack of Direct Communication Between Referring GPs and Reporting Radiologists
There is no direct communication between referring GPs and reporting radiologists working for private providers. This makes it difficult to ask questions and resolve ambiguities or discrepancies in scan interpretations.

Public radiologists have reported that GPs have sometimes raised concerns or suggested serious possibilities to patients without sufficient clinical evidence, based on the report from a private radiologist. This premature communication of potential diagnoses, without confirmation from diagnostic tests or specialist input, has led to unintended anxiety or distress for patients.

Unnecessary, Inappropriate or Redundant Scans
Some public radiologists expressed concerns that there is a current culture around unnecessarily referring patients for scans, rather than ensuring that scans are being conducted when it is clinically appropriate. However, they did acknowledge that the guidelines provided by the Irish College of General Practitioners (ICGP) were appropriate.

Public radiologists reported that repeat scans are frequently required, often due to the poor quality of the initial imaging. In other cases, scans must be repeated because of errors in the original clinical judgment, for example, if the wrong type of scan was ordered, if key clinical information was missing, or if the scan did not target the appropriate area. These repeat scanning procedures not only cause delays in diagnosis and treatment, but also place additional strain on radiology services and may increase patient anxiety or inconvenience.

> "We just have to repeat those scans in the hospital, so they don't reduce the number of scans at all. If anything, they increase the number of scans that the hospital has to do."

When scans need to be repeated, radiologists working in public hospitals have few options, as there are long waits to access public facilities and they are unable to access the GPACD scheme. Therefore, some indirectly access the scheme by contacting patients' GPs directly and asking them to re-refer the patient for a specific scan.

Unclear Governance and Accountability in Private Scanning Services
One radiologist raised concerns about the use of public funds to provide services which are questionable in terms of their quality, impact on wait times, and efficacy in improving patient outcomes. They also raised important questions about who holds responsibility for overseeing and ensuring the quality, safety, and follow-up of private scans. This includes concerns about who interprets the results, who communicates them to the patient, what happens if a serious issue is detected, and how these findings are integrated

into a patient's overall care plan—particularly when the scan is carried out outside the public health system. The lack of clear governance or accountability structures can lead to confusion, gaps in care, and potential risks to patient safety.

The GPACD scheme relies heavily on private scan providers to reduce wait times and is being funded by taxpayers, raising philosophical and governance questions about public healthcare resources being diverted to private entities.

> "I suppose the other issue, kind of philosophically, is that these scans are being, you know, conducted in private scanners by private entities and paid for by the taxpayer, essentially."

6.7 Mental Impact on Patients

Reports of incidental findings or ambiguous results, such as the potential for a sarcoma later dismissed, create unnecessary worry. One specialist consultant stated that in their professional experience, waiting to see a specialist "does definitely add to anxiety, because, you know, I don't necessarily know that GPs have the knowledge to be dismissive of reports of a scan."

At this point, the patient is waiting to see someone as they have been told that "they have some abnormality". By the time they are able to see a specialist, the patient may have been waiting for 12 months, with the belief that something about the scan was abnormal.

This may lead to fear-driven presentations at emergency departments and can be compounded by a lack of understanding of medical jargon in GP referrals and diagnostic results reported without sufficient context or consultation.

> "Because, you know, the sort of, the health-seeking behaviour of people is very often driven by fears and anxieties about what might be going on. And you know, quite a lot of people turn up at the emergency department because they're so afraid there's something serious wrong, and they really want to be checked out and get the scan."

6.8 Geographical Challenges: Location, Distance and Costs

Rural Access

As with other aspects of accessing healthcare, some patients may face considerable challenges traveling to appointments, particularly if they lack personal transportation, as some diagnostic facilities are located in inaccessible areas. These barriers include:

- Long travel times

- Access to public transport
- Cost of transport

In addition to these geographical barriers, disparities arise from the placement of some private diagnostic facilities in locations that are difficult to access without a personal vehicle. This creates inequities for patients reliant on public or community transport. The financial burden of transport costs, including public transit fares or fuel expenses, further compounds these challenges, particularly for rural residents and those lacking support networks. To address these barriers, some healthcare providers actively coordinate transport through local services for patients who otherwise would struggle to attend appointments, highlighting the importance of community-based solutions for equitable healthcare access.

It was highlighted that these challenges are particularly difficult for patients who live in rural areas as they have fewer transport options and have greater travel distances.

Urban Access
Even in urban areas the location of facilities in relation to public transport routes was indicated as a factor for GPs when choosing which provider to refer patients to. Some referrers are aware of the transport challenges faced by some of their patients and "sometimes [they'd] have to organise transport" for patients because "a lot of [their] patients don't have cars."

6.9 Areas for Expansion and Improvement

Education for General Practitioners
Radiologists recommend providing educational sessions for GPs to enhance their understanding of diagnostic pathways and improve adherence to clinical guidelines, with the goal of ensuring better patient outcomes. One suggestion included organising evening training sessions similar to those offered in other specialties, where GPs could receive focused talks on the importance of following established guidelines. Such targeted education would help reinforce best practices and support GPs in making more informed decisions within the diagnostic process.

Some noted that although education would empower GPs with up-to-date knowledge and best practices, primary care staff are hard pressed with a variety of competing priorities. Therefore, measures should promise to streamline workflows, reduce unnecessary referrals or tests, and promote more equitable and effective care within the system.

Clinical Decision Support Tools for General Practice
There was growing optimism about the potential benefits of integrating clinical support tools into the healthcare system, as the possibility for these tools to significantly improve clinical decision-making and ensure better adherence to established guidelines was noted. Healthcare providers stated that by providing real-time, evidence-based support, these tools could help them to make more accurate and consistent decisions, ultimately leading to improved patient outcomes. One doctor stated:

> "I think the big thing will be the clinical decision support tools when they come online, and they're patchily coming in some areas, but they will be in the next couple of years completely integrated into the national system."

Specialist consultants highlighted that when combined with targeted educational initiatives for GPs, clinical support tools could enhance the overall efficiency and appropriateness of the GPACD scheme.

Need for Centralised and Standardised Mechanisms
Healthcare providers repeatedly stated that many private providers were not integrated into the NIMIS, which creates challenges to radiologists in accessing historical imaging records (e.g. X-rays). Stakeholders emphasised the importance of connecting private diagnostic providers to public systems to ensure seamless access to patient records and improve overall service coordination. It was suggested that such system integration would reduce duplication and delays in accessing necessary diagnostic images, whereas the current lack of integration limits continuity of care and hampered diagnostic efficiency.

Increased Access to Specific Modalities
Healthcare providers stated that DEXA scanning had limited availability, with only two centres serving the large population of Dublin. They state that there was a proposal in place to expand these facilities to underserved regions, such as Cork and Limerick, to improve access. Stakeholders expressed a clear need for more DEXA scanning clinics beyond Dublin to better meet demand and provide equitable service across different areas.

Ultrasound
Significant challenges existed in accessing ultrasounds, particularly for patients who lack a medical card. GPs expressed concerns and stated that more inclusive and widespread provision is necessary.

Inequitable Access and the Need for Ring-Fenced Public Resources
Concerns were raised about the stark difference in wait times between patients referred by GPs versus those referred by hospital specialists, with the

latter facing significantly longer delays. This disparity highlights potential inefficiencies in the referral pathway and may contribute to unequal access to timely diagnostic services, ultimately affecting patient outcomes.

They also criticised that through outsourcing to private providers, Sláintecare principles are being undermined by fragmenting the system and prioritising efficiency over equitable care.

> "It's very inequitable that you know, a patient who comes to see a neurologist in a hospital has to wait two years for a scan, whereas someone that goes to their GP can get a scan in a couple of weeks."

Healthcare providers called for greater investment in public hospital radiology services to address inequities. The highlighted that specialists in hospitals often face prolonged wait times for scans, whereas GPs can obtain diagnostics more quickly under the GPACD scheme. One hospital consultant stated:

> "There has to be more resourcing ring-fenced within the acute hospital system, or doesn't even have to be necessarily an acute hospital system, just a radiology resource has to be ring-fenced for that core to people, so that specialists can access the scans in an equitable way to generalists, who are probably largely looking to rule anything sinister."

Strategic Expansion

While stakeholders acknowledge the importance of increasing diagnostic availability to meet growing patient demand and improve access to care, they also caution against uncontrolled or rapid expansion of diagnostic services. Their concerns centre on ensuring that any growth is both cost-effective and clinically appropriate, avoiding unnecessary tests or procedures that could strain healthcare resources without delivering meaningful benefits. Stakeholders emphasise the need for careful planning and evaluation to balance expanding access with maintaining high standards of care, ensuring that diagnostic services are used judiciously and contribute positively to patient outcomes. This approach aims to prevent wasteful spending and inefficiencies while promoting sustainable improvements in healthcare delivery.

Sustainability Concerns

The current reliance on private providers to deliver diagnostic services through the GPACD was widely viewed as a temporary measure designed to address immediate capacity shortfalls and reduce waiting times within the public system. However, stakeholders emphasised that this approach is not sustainable in the long term, as it currently leads to fragmented care, challenges in maintaining consistent quality across the healthcare system, and potentially to increased costs.

Though scans through the GPACD scheme occur comparatively quickly, patients then end up on long outpatient wait lists (see the section on the NTPF for details). In addition, hospital outpatients still face long waits to access diagnostic imaging services. In order to alleviate the waiting for some patients, GPs are sometimes asked to re-refer their patients for follow-up scans through the GPACD (see the section on GP workload, for more information).

Reflecting concerns about the long-term strategy for diagnostic services, one consultant questioned the reliance on private providers, asking, "Rather than outsourcing to a private provider, shouldn't the resources be put into the public facilities to increase the ability to manage patients within the public system?"

For lasting improvements, there is a strong call for significant investment in expanding and upgrading public diagnostic capacity. Strengthening public facilities would help create a more integrated, equitable, and resilient healthcare infrastructure capable of meeting future demand without overdependence on private providers. This strategic shift would also support better coordination of services, enhance access for all patient groups, and promote more efficient use of resources over time.

> "I mean, in general, I would favour getting scans done in the hospital. Everything about that is preferable for the patients attending the hospital, it's different if it's patients who are attending a GP and are not attending a hospital."

7. Discussion

7.1 Summary of Major Findings

Through an assessment of NTPF data published by the Oireachtas it was possible to assess the waiting times and number of individuals on public outpatient waiting lists for some of the diagnostic imaging scans. These data show a large number of patients waiting and that Sláintecare targets are consistently not being met. Unfortunately, there are no national level data available to assess the number of patients awaiting GPACD appointments. In addition, the number of scans reported by the HSE reflect the number of cases rather than unique patients.

Both survey and interview data reflect overall support of the scheme, with stakeholders applauding the HSE's efforts to reduce patient wait times for diagnostic imaging. This study adds to the current evidence that the GPACD scheme is having positive impacts on patients' care in the early part of their

clinical journeys by giving them faster access to initial diagnostic services. Additionally, there was a strong desire for increased transparency about the scheme and formal mechanisms to report and address poor provider performance within the scheme. The survey data from GPs provides broad confirmation that the GPACD scheme improves access, reduces wait times, and enhances referral quality, while increasing GP workload and exposing communication and equity challenges. The interview data obtained from a variety of stakeholders enriches this picture with detailed insights into systemic bottlenecks, governance issues, patient mental health impacts, and operational challenges, especially around language barriers, data integration, and provider variability. Future expansion of the scheme would be welcomed. However, there is a need to address systemic barriers to access and conduct assessments of the scheme's performance from a variety of perspectives.

The GPACD scheme in its current form also introduces significant administrative and operational challenges. It adds an unresourced administrative workload for general practices, which can strain existing resources. Additionally, there is a risk of scan duplication if hospital doctors are unable to access images digitally, potentially leading to inefficiencies and increased costs.

These perspectives offer a comprehensive understanding of the scheme's strengths and areas for improvement, highlighting the need for:

- Enhanced communication and support for primary care staff's administrative role in managing patient referral processes
- Enhanced communication and support for GPs' role in interpreting scans
- Addressing language and digital access barriers for vulnerable patients
- Improving integration and quality assurance of private scan services
- Strengthening public diagnostic capacity to reduce reliance on private providers
- Systematic evaluation and stakeholder engagement for sustainable development

This combined analysis underscores the complex interplay between patient care improvements and systemic challenges within the GPACD scheme.

7.2 Interpretation of Findings

Little Patient Awareness of the Scheme
While recruiting interview participants, we realised that many people are not aware of the GPACD scheme, even when they have previously availed of it. Limited awareness of the GPACD scheme's existence among patients poses a significant challenge to evaluating its impact from the patient perspective. If

individuals are unaware of the scheme or do not fully understand how it operates, they are unlikely to engage with it meaningfully or provide informed feedback in an appropriate manner to the right authority. Also, this lack of familiarity hindered efforts to assess the scheme's effectiveness, relevance, and overall impact on patient experiences and outcomes. Lastly, limited awareness of the GPACD scheme can significantly impact a patient's ability to give informed consent and to actively participate in healthcare decisions.

Unclear Effect on Waiting Lists
Limitations in reporting (e.g. NTPF) make it difficult to gauge the true scale of waiting lists or to fully understand the impact of interventions aimed at reducing these long waits, such as the GPACD scheme. As reiterated in a recent discussion, the introduction of a unique health identifier would significantly improve the ability to track the number of distinct individuals on waiting lists, providing clearer insights into both the extent of the problem and the effectiveness of targeted measures (HMI, 2023).

In addition to the challenges around assessing the efficacy of the GPACD scheme based on standard and transparent national data, the results from this study point towards systematic bottlenecks and deficits that may actually result in prolonging patient waits as well as inappropriate resource use (from a clinical perspective). Previous studies assessing the GPACD focused on the perspective of GPs, however, here we also consulted with a wider range of stakeholders, including hospital consultants and radiologists. These service providers would be further along the patient pathway and should be consulted directly on the scheme's efficacy and impact on their areas of expertise, as such a systematic assessment is currently lacking from the government. Also, a long-term assessment of patient outcomes, paired with financial data would also prove to determine if the GPACD scheme is ultimately effective in benefitting the health outcomes of patients.

Complications of Outsourcing Services
As highlighted in the introduction, Ireland's healthcare provision is supported heavily by private service providers. It has previously been shown that an outsourcing model can enable healthcare providers to overcome a number of obstacles across their operations associated with staffing, supply chain inputs and enabling systems. Public system challenges in these areas predominantly relate to staffing difficulties (e.g. lack of clinicians within the public system), insufficient resources (e.g. scanning equipment), efficiency, and cybersecurity. However, setting aside these management and delivery responsibilities, outsourcing services to private providers has been found to be successful. For example, within Connolly Hospital in Dublin, the outsourcing of emergency CT scans led to a significant reduction in wait times among patients suffering from a suspected stroke, thereby enabling

patients to be admitted and access medication and rehabilitation sooner (Joyce, 2023). Within the GPACD scheme in particular, outsourcing aims to shorten wait lists for patients by increasing access to diagnostic radiology scans.

Outsourcing healthcare can come with flaws, however. While sometimes necessary in emergency situations, using public funds to access private services in the long term may raise concerns about cost-efficiency. Investing in public services to reduce the need for outsourcing to private providers could improve the sustainability of healthcare practices. For example, in April 2020, the Irish government paid private hospitals to access their capacity and services to mitigate the strain placed by the COVID-19 pandemic on Ireland's already over-extended public hospitals (Mercille et al., 2022). Since then, concerns have been raised that this outsourcing model is being used too widely and calls have been made to shift the focus to long-term investment in public resources (Griffin, 2022), with St. James's Hospital Chief Executive Mary Day stating:

> "It is not the solution. I think it was a quick fix in relation to an emergency situation but two years later, that we are still relying on that as a solution to the problem is doing harm to what we are trying to achieve."

In this vein, the findings in this study bring to question the sustainability of the GPACD scheme in relation to long-term patient needs and primary care resources.

Issues relating to quality of care in outsourced health services have also been raised. The 2018 CervicalCheck scandal, in which over 200 women developed cervical cancer (and at least 20 have since died) after receiving false negative results in cervical screenings (Carroll, 2022; O'Loughlin, 2018), has largely been attributed to the outsourcing of sample testing to foreign laboratories where sufficient standards of care were not ensured (Scally, 2018). Speaking of outsourcing more generally, some politicians have described the practice as "a question of shirking responsibility" for potential mistakes in care provision (Oireachtas, 2023f). It is therefore crucial that, where outsourcing is necessary, contractors have substantial industry knowledge, follow best practice guidelines, and are regularly monitored to ensure that quality standards are maintained.

In the context of outsourcing in radiology more specifically, the European Society of Radiology (European Society of Radiology, 2021) noted that improved and direct patient-radiologist communication is important to patient satisfaction. This communication is lacking if the patient receives their imaging results through their GP, as is the case in the GPACD scheme. In

addition, diagnostic accuracy may suffer if the diagnosing radiologists does not have access to contextual information about the patient's condition and changes therein over time, prior imaging records, and medical history (Berry et al., 2021). This concern was also raised during interviews with consultant specialists, who were unclear of comments made by GPACD radiologists and believed that some of the confusion may have been due to lack of access to the patient's full medical records. The consequences of this lack of direct interaction with the radiologist and the patient range from patient dissatisfaction, to needing additional avoidable and expensive testing, to delays in treatment and consequent impact on the patient's quality of life and health outcomes (Berry et al., 2021). Finally, as also found in this report, off-site radiologists may face barriers in communicating with the patient's referring GP, thereby lowering the standard and continuity of care (Berry et al., 2021).

Ethics Around Outsourcing

The GPACD scheme primarily targets primary care and access to services via a patchwork of private providers, each operating with its own independent systems. Consequently, both GPs and patients must navigate varying infrastructures and eligibility criteria, which can create confusion and barriers to care. While the HSE has attempted to mitigate these issues through a host of guidance documents, these remain vague and fall short of fully addressing the concerns highlighted in this report. More support is needed to ensure smooth transitions for patients and the GPs that support them through this process.

There are also ethical concerns around resource allocation and the overall system impact. It is clear that through the GPACD scheme, patients are accessing diagnostic imaging faster than they would through public hospitals. However, healthcare providers pointed out negative feelings as they perceived a preference for relying on private providers rather than investing in public hospital radiology capacity–potentially conflicting with the spirit of Sláintecare. The true effect of the scheme on freeing up public hospital radiology resources remains unclear as public waiting lists have not been significantly reduced and specialist consultants have stated that they sometimes request that GPs refer patients for follow-up scans through the GPACD scheme. Furthermore, questions persist about the overall effectiveness of private radiology service provision for public patients, despite the high volume of scans organised through the scheme.

Guidelines and Regulation in a Community Setting

The Environmental Protection Agency oversees radiation safety standards and enforces compliance with national and EU regulations on ionizing radiation use. The Irish Medical Council and HIQA also play roles in monitoring clinical standards and patient safety in radiology services. Hospitals and

diagnostic centres conduct regular audits of imaging practices, often aligned with European guidelines, such as those from the European Society of Radiology (e.g. The Basic Safety Standards Directive (European Directive 2013/59/Euratom)), while the HSE issues clinical guidelines and protocols for radiology practices, including appropriate imaging referrals and the use of diagnostic imaging to optimise patient care and minimise excess exposure (for example, the HSE's letter to GPs (HSE, 2024)).

By broadening the settings in which diagnostic imaging is occurring, GPs are now required to monitor imaging use in the community setting. Audits and compliance monitoring to assure alignment with national and European guidelines, which would traditionally have been undertaken by hospitals and radiology centres now need to be conducted at the primary care level as well. GPs and primary care teams, who are already over stressed, are required to manage the radiology exposure records of their patients across multiple potential providers and diagnostic types. With the national prevalence of the GPACD scheme and volume of patients supported annually, full system integration is urgently required. Additionally, robust oversight and coordination is needed to maintain safety, quality, and guideline adherence while enhancing patient access to timely diagnostics.

Vulnerable Populations Without GP Access

This research shows that GPs, often aware of the challenges faced by some of their most vulnerable and marginalised patients, try to find ways to balance the challenges in accessing the GPACD scheme. In previous sections we have discussed the additional burden that the GPACD scheme places on primary care providers. However, there are additional concerns associated with the proportion of the population who cannot access a GP to obtain a referral. Many patients face difficulties in accessing GPs (Oireachtas, 2023f). It has been estimated that 385,000 (or 10%) of adults living in Ireland do not have a GP (Barrett, 2023). This shortage is linked to uneven GP distribution, with some areas like Lucan and parts of Dublin experiencing particularly poor GP-to-population ratios, reaching nearly 4,000 people per GP in some regions, where the national average is approximately 1,759 (Irish Independent, 2025; Sherlock, 2025).

This, in turn prohibits patients who lack a GP from being able to benefit from the GPACD scheme. The HSE have indicated that GPs are an essential tool for referring patients to diagnostic assessments and reducing pressure on emergency departments (Oireachtas, 2023f). However, in both rural and urban areas patients struggle to access primary care services in a timely manner (Oireachtas, 2023f).

Although there are some digital GP services available in Ireland, it is not clear what role they play, if any, in the GPACD scheme. Therefore, without access

to a GP, it is not possible to participate in the GPACD scheme and patients must present to public hospital services or pay privately to access diagnostic imaging (if the private provider accommodates patients without a GP referral). In order to maximise the benefits of the GPACD scheme, improving access to primary healthcare is essential.

Sustainable Development Goals
Here, we provide evidence that the GPACD aligns with several of the United Nations Sustainable Development Goals (SDGs) (United Nations, 2015) by promoting more equitable healthcare:

- SDG 3: Promote health and well-being for people of all ages.
- SDG 10: Reduce inequalities by improving access and improving waiting times for patients regardless of socioeconomic status.

This is accomplished through increasing access to diagnostic services through taking advantage of infrastructure and services provided by private providers. This has increased access to diagnostic services to the 42% of the population in Ireland holding medical cards and GP visit cards who, presumably, would not have been able to afford access to a GP or private diagnostic services otherwise. GPACD services could further reduce inequalities by improving system integration and reducing language barriers.

In addition, we found evidence that the GPACD does not support efficient and sustainable healthcare provision (SDG 12). These include increased GP workload, transfer of bottlenecks to specialist consultants, repeated diagnostic imaging needed due to quality concerns, and potentially direct financial competition with resourcing public services.

7.3 Expansions to the Scheme

As discussed in the literature review, the spread of the GPACD scheme nationally has been heterogenous, with diagnostic availability being hindered by the availability of private providers in certain geographic regions of the country. The cause of this uneven distribution was the variability in diagnostic availability, which is closely linked to the presence or absence of private healthcare providers in specific geographic areas. In regions where private diagnostic services are scarce or non-existent, access through the GPACD scheme tends to be more limited, thereby affecting the overall reach and effectiveness of the programme. It is not clear what criteria were required for private providers to become included in the GPACD scheme. These patterns may have also been reflected in access to public hospital services, as rural areas were strongly affected.

Our data support the premise that as the scheme has expanded geographically and by diagnostic type, the experiences of individuals and

aspects of the health systems varied. For example, in some urban areas where the scheme had been well-integrated and diagnostic services are more readily accessible, GPs had more choice in providers and selected those that were the easiest to work with and were of the most benefit to their patients. Conversely, this means that in underserved regions, GPs had fewer choices and patients might still face barriers to timely diagnostics, which can influence health outcomes and satisfaction with care.

7.4 Alternatives to the Scheme

As demonstrated by the NTPF waitlist data, it is necessary to find immediate solutions to reduce the waiting time for patients seeking diagnostic imaging. However, at the moment it is not clear if the GPACD will be a short- to medium-term solution to alleviate the strain on public hospitals, or if it will remain in place in the long-term. In addition, it is not clear if substantial financial investments are in place to increase the capacity of public hospitals to reabsorb the responsibilities of supporting the hundreds of thousands of patients who are currently utilising the GPACD scheme.

Certainly, the GPACD complements existing pathways and options for patients needing diagnostic imaging or related services. Historically, direct support to hospital infrastructure has been well received. For example, early efforts to improve GP access to DEXA scans began in 2006, when three acute hospitals in Leinster were allocated funding to purchase DEXA machinery, available to use for all patients in the catchment area by GP referral (Ghuffar et al., 2008). A total of 276 GPs were eligible to refer to this service, free-of-charge to the patient. Evaluations of the scheme indicated that patients and GPs were largely satisfied with the scheme, but the need to further improve waiting times was nonetheless highlighted (Ghuffar et al., 2008). Prior to the introduction of the GPACD scheme, wait times for DEXA scans in the public system were up to 24 weeks, while a private patient could access a scan within a week of referral (O'Riordan et al., 2013). Direct GP access to diagnostic services has also proven to be beneficial in other jurisdictions (Phelan et al., 2023). However, direct access to diagnostic imaging could also happen through the public system if sufficient public resources were made available to meet the population's growing needs.

In the September 2025 National Performance Report it is noted that construction of new diagnostic imaging suites are in progress at major trauma centres (HSE, 2025b). It is not clear when these additional suites will be available, what their expected capacity will be and what the future plans are to fill in geographic service gaps (e.g. in rural areas). An assessment of NTPF data at the hospital level and direct consultation with hospital consultants would pinpoint the areas of immediate need. Ideally, this should be

performed in conjunction with an assessment of the payments made by the HSE to private providers receiving GPACD referrals. Expanding capacity in public hospitals will certainly require significant and persistent long term financial commitment.

Similarly, public funds should continue to be utilised to run more public mobile health teams which would be linked directly with HSE services, rather than paying private providers. For instance, public health authorities fund mobile health and screening units operated by community care programmes. These units are staffed by multidisciplinary teams, including radiographers, and are equipped with diagnostic imaging tools such as X-ray machines. Additionally, partnerships with various service providers at fixed community locations help deliver urgent diagnostic imaging outside of hospital settings.

7.5 Recommendations

1. **Enhance Communication and Support for GPs**
    - Develop clear, accessible guidelines to aid GPs in interpreting scan reports and making specialist referrals.
    - Provide targeted educational sessions and training on diagnostic pathways and guideline adherence.
    - Integrate clinical decision support tools within general practice to improve referral appropriateness and consistency.
2. **Improve Integration and Data Sharing**
    - Ensure that all private scan providers report to the NIMIS to enable seamless access to imaging records for GPs, radiologists, and specialists. Radiologists working for private providers should also be able to access patient medical records on the NIMIS in order to increase their diagnostic accuracy.
    - Establish direct communication channels between referring GPs and reporting radiologists to clarify findings and reduce ambiguity.
3. **Address Language, Literacy, and Digital Barriers**
    - Mandate provision of interpreter services and translated materials by private scan providers to support non-English-speaking patients.
    - Develop simplified, multilingual patient information and appointment instructions.
    - Support patients with limited digital access by offering alternative methods for form completion and appointment management.
4. **Reduce Geographic and Transportation Barriers**
    - Where possible, prioritise locating diagnostic services in areas accessible by public transport, especially in rural and underserved regions.

- Facilitate transport support services for patients lacking private vehicles to ensure appointment attendance.

5. **Strengthen Public Diagnostic Capacity**
   - Invest in expanding and upgrading public hospital imaging facilities to reduce overreliance on private providers.
   - Ring-fence resources within public hospitals to ensure equitable access to scans for both hospital specialists and GPs.
   - Assess patient pathways, with an outcome-based focus, to allow for smooth transitions between GPs, private providers and the public hospitals.
6. **Improve Quality Assurance and Governance**
   - Implement systematic audits evaluating clinical outcomes, cost-effectiveness, workload impact, provider performance, and patient outcomes.
   - Establish transparent accountability frameworks for private providers, including adherence to professional standards and reporting protocols.
   - Foster ongoing consultation and engagement with frontline clinicians, radiologists, and patients to inform scheme development and improvement.
7. **Manage Workload and Referral Pathways**
   - Streamline referral and follow-up processes to reduce administrative burden on GPs and avoid duplication of scans.
   - Develop protocols to minimize unnecessary or inappropriate scanning, ensuring scans are clinically justified.
8. **Support Patient Understanding and Experience**
   - Increase patient awareness of the GPACD scheme, its purpose, and navigation through targeted outreach and education.
   - Provide clear explanations of scan results and implications to reduce anxiety, particularly concerning incidental or ambiguous findings.
   - Enhance coordination between GPs, specialists, and diagnostic services to ensure timely and compassionate patient communication.
9. **Plan Strategic and Sustainable Expansion**
   - Approach expansion of diagnostic services with careful planning to balance demand, cost, and clinical appropriateness.
   - Prioritise long-term sustainability by strengthening public sector capacity and reducing fragmentation in care delivery.

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Appendix 1 - Scanning Process

CT, DEXA, MRI, X-Ray, and ultrasound scans are typically performed by radiographers and analysed by radiologists. The process of receiving and interpreting radiological scans is multi-faceted and there may be multiple steps involved in the process of a patient receiving their scan results. The following sections will highlight the key steps in the process, the personnel involved, and the potential challenges.

Personnel and Key Steps

Diagnostic scans are carried out by radiographers. However, upon conducting the diagnostic scan, radiographers are not trained to interpret the scans. Instead, they must be interpreted and reported on by the consulting or diagnostic radiologist on staff. Radiologists then communicate the relevant information back to the referrer for communication to the patient. The process involves at least three professionals (radiographers, radiologists, and GPs) before the outcome can be shared with the patient, creating multiple opportunities for delayed results.

Referring General Practitioner

All patients availing of the GPACD scheme must be referred by a GP. HSE guidelines advise that patients needing a scan within less than four weeks are referred through the standard referral process (i.e. not through the GPACD scheme), as even urgent referrals through the scheme can take up to a month. Referrals are accepted online through Healthlink. The referring physician must provide a range of information about the patient, including details of their location, healthcare entitlements, and prior scans, as well as information on the current scan required (see Appendix 2). Upon receipt, the referral is reviewed by a radiologist or senior radiographer to assess urgency and eligibility, before the patient is contacted to arrange the scan.

Radiographers

The physician's referral is directed to the radiographer, who is responsible for conducting the diagnostic scan. Radiographers are healthcare professionals who operate the scanning equipment but are not medical doctors.

The Irish Institute of Radiography and Radiation Therapy is a charitable organisation and the professional body for radiographers and radiation therapists in Ireland. The Institute facilitates the professional development of its members, but membership is not compulsory for practicing clinicians. Instead, all practicing radiographers in Ireland are required to register with CORU - the organisation responsible for regulating Ireland's health and social care professions. Eligibility to register is dependent on the applicants' qualifications; currently, four radiography degrees in Ireland are approved by

CORU as sufficient for registration[2]. Applicants with non-Irish qualifications are assessed by comparing the qualification with the standard required of accredited Irish qualifications[3]. Successful applicants are registered radiographers on the CORU database, with 3,965 registered in February 2026.

Radiologists

The Medical Council is responsible for the accreditation of medical doctors working in Ireland, including radiologists, with eligibility for registration depending upon the country (i.e. Ireland/EU/non-EU) and educational institute where the degree was obtained. Doctors who obtained their medical degree in Ireland or elsewhere in the EU/EEA can apply for automatic recognition of their qualifications. For doctors who qualified outside of the EU, EEA, or Switzerland the applicants must have their medical education credentials verified in advance of making their application for registration, through the Electronic Portfolio of International Credentials of the Educational Commission for Foreign Medical Graduates.

To obtain licensure in radiology, accredited medical doctors must then complete a five-year postgraduate training programme through the Faculty of Radiologists and Radiation Oncologists within the Royal College of Surgeons in Ireland (RCSI). Upon successful completion of the programme, newly qualified radiologists may be included on the Specialist Register of the Medical Council of Ireland and can apply for posts in the field.

The number of consultant radiologists in post in Ireland is consistently lower than the European average of 12.8 radiologists per 100,000 population (Lynch, 2022; NRQIP, 2020; RCSI, 2026). The RCSI states that the "ratio of consultants to population is low in comparison to some of our neighbouring countries, and the numbers of studies performed by individual consultants is quite high by international standards. Understandably, this places great pressure on practicing radiologists and radiation therapists" (RCSI, 2026).

The 2020 National Radiology Quality Improvement Programme Report emphasises the risk of error caused by overloaded staff and stresses the need for more trained radiologists (NRQIP, 2020). The 2024 National Radiology Quality Improvement Programme summary report reaffirms this emphasis, stating that there are year-on-year increases in diagnostic scans (NRQIP, 2024). Radiology departments are under a lot of pressure because they have

[2] The list of approved qualifications is available here: https://coru.ie/health-and-social-care-professionals/education/approved-qualifications/radiographers-and-radiation-therapists/.
[3] Further information about CORU's recognition of international qualifications is available here: https://coru.ie/health-and-social-care-professionals/international-qualifications/apply-for-recognition/.

to handle more and more complex cases and a higher number of cases, but they still don't have enough staff or resources to keep up (NRQIP, 2024).

Appendix 2 - GP Referral Information

Table A1. Information required on GP referral to GPACD scheme.

#	Information required	Example
1	Code: "GP Access to Community Diagnostics"	GP Access to Community Diagnostics *or* blank, if referring for ultrasound
2	Community Health Organisation	CHO 1
3	County	Cavan
4	Medical card or GP visit card number (only for ultrasound)	A1B23456C
5	Modality	CT
6	Part of the body to be scanned	Sinuses
7	Urgent or routine	Routine
8	Patient's mobile number	0851234567
9	Relevant clinical information, including previous imaging and where this was done	Brain MRI at St. James' in Dublin

Source: Health Service Executive, August 2023

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