General Practice – New Models

Pathways to the Future

ICGP Winter Meeting 2004

Introduction

- Cork City GP (previously rural GP)
- ICGP Council 1993-96
- IMO GP Committee 1999-date
- GP Practice Development Team
- Developed 4,000 sq. ft. premises 2001
- Individual views

Primary Care Strategy (2001)

- Slow development of existing projects
- No funding of new projects
- “Deferral” of spending until 2007
- Extensive “mapping” exercise
- ? Selective implementation of non-cost incurring elements of the strategy

Relationship with Government

"*Hell hath no fury like a bureaucrat scorned*"

- Milton Friedman

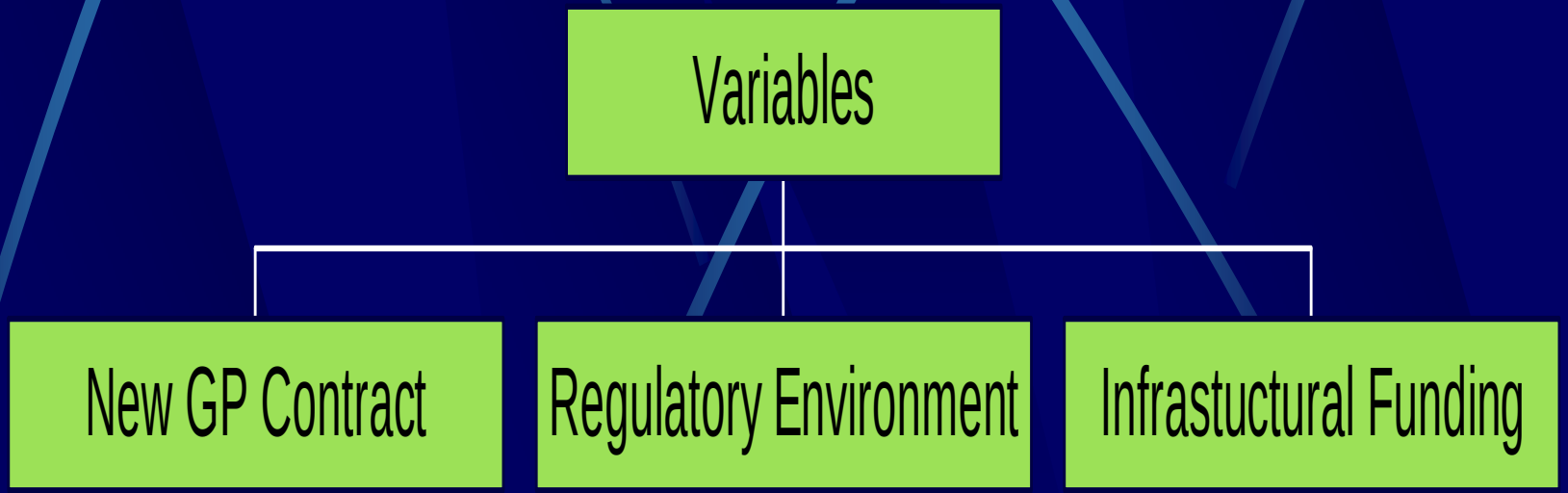
Relationship with Government

- Non-implementation of agreements already entered into in good faith
- No progress on issues under discussion
- Denial of normal pay rounds under social partnership

General Practice 2014 - utopia

- Independent
- Well resourced
- Quality service
- Broader range of services
- Motivated practitioners with high morale
- Flexible career pathways

Future Practice Models



New GP contract

"Experience is simply the name we give our mistakes"

- Oscar Wilde

Spain

- Salaried GPs
- Incomes € 25-35K
- State-owned infrastructure
- De-motivated and demoralised GPs
- 12 consultations per hour (+ extras)

Australia

- Urban vs. Rural
- Corporatisation
- Single payer
- Falling incomes
- Collapse of largest medical insurer

Canada

- Fee per item
- Single payer
- Fee capping
- Defeatist leadership leading defeated GPs

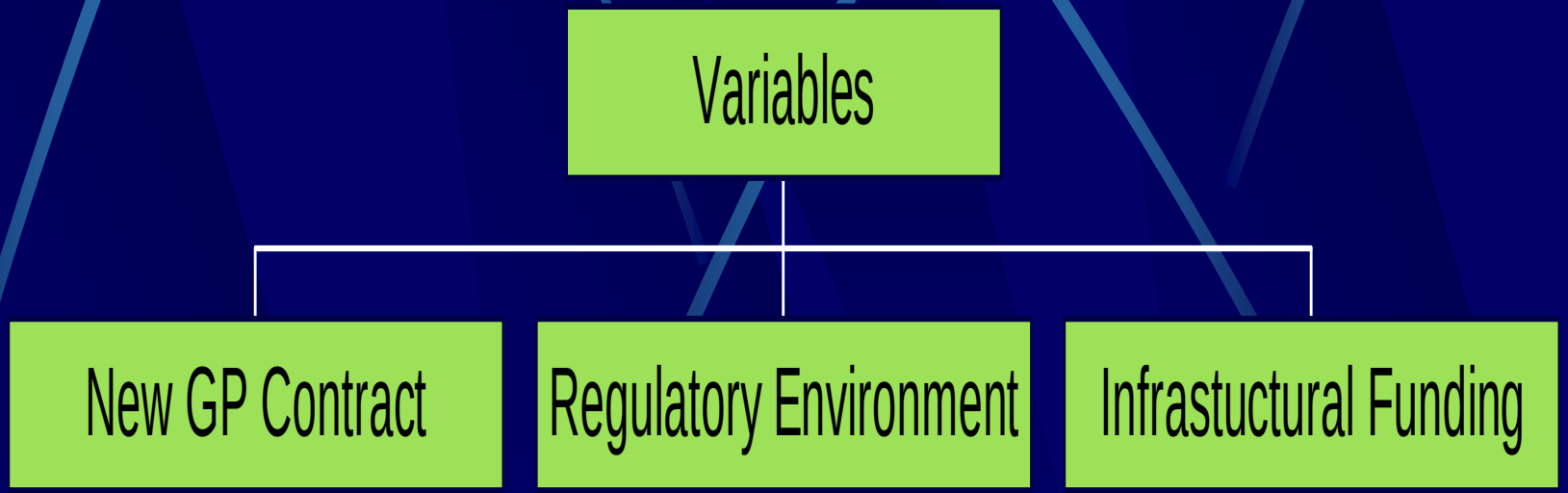
New GP Contract

- Normal IR machinery must continue
- GPs' model should be non-prescriptive
- General Practice is part of the solution, not part of the problem

New GP contract - priorities

- Contractor status enshrined
- Incentives to group and provide infrastructure
- Multiple payers
- Flexibility – part time working
- Out-of-hours
- Chronic disease management schemes
- Properly resourced CME & CPD
- Enhanced role of nurses and AHPs
- Special procedures
- Over 70s agreement inequities removed

Future Practice Models



GP Regulatory Environment

- Competition Authority – examination of all the professions
- Indecon Report March 2003
- More detailed examination of Medical Profession awaited

Indecon : Barriers to Competition

- Restriction of Medical School entry
- Restriction of GMS contracts
- GP-Consultant referral
- Restrictions on doctors advertising
- Preclusion of GPs from operating within limited liability structures

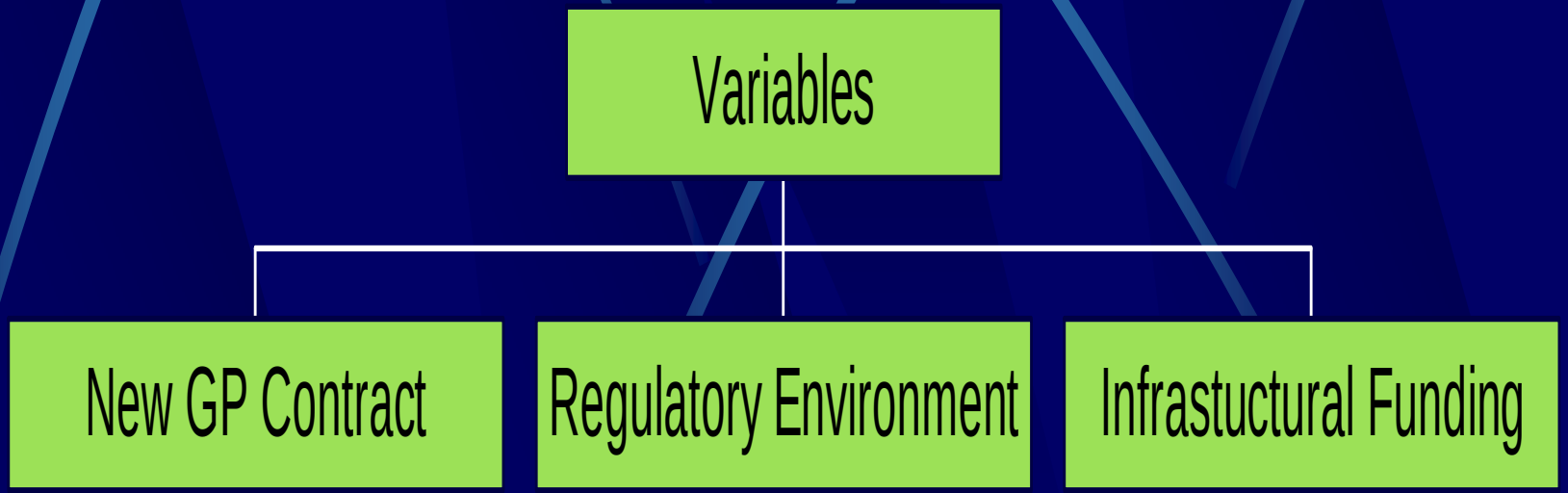
Corporatisation of Australian GPs

- Since 1998 – rapid buy-up of “goodwill” of GP practices by Corporations
- Relocating many GPs to urban practices
- “Vertical integration” – pathology & radiology
- Imbalance in relationship between GP and employing corporation
- Patient vulnerable to 3rd party exploitation

AMA – factors influencing pace & nature of Corporatisation

- Parlous state of GP remuneration
- Paucity of practice management training
- Increased public expectation re. premises, hours, equipment etc
- Length of hours rqd. to earn target incomes
- More part time GPs happy to relinquish practice ownership
- Demand for family-friendly working conditions
- 24 hour cover and shortage of locums
- Absence of new GPs to share practice loads

Future Practice Models



Infrastructure funding

- IDTS still only state source of capital funding
- IMO – Department of Finance meeting
- IMOFS – tasked with developing a new financial model
- All avenues to be explored
    - Capital allowances
    - Capital grants
    - Cost-rent scheme (or similar)
    - Enhanced pension provisions
    - “IPOS”-type model

Pharmacy

- State of flux
- Deregulation 2002
- IPU: > 40% of pharmacies owned by chains
- IPOS
- Uniphar (owned by 400 independent pharmacies)– purchased 105 pharmacies in 3 years

Pharmacy Income (from GP)

GMS	€ 651m.
DPS	€ 204m.
LTI	€ 73m.
PP Px (non-DPS)	€ 300m. (est.)
OTC's	€ 200m. (est.)
Non-drug items	€ 200m. (est.)
TOTAL	**€ 1,630m.**

Pharmacy Income (from GP)

- General Practice with 6 WTE's
- Generates € 4.5m. turnover
- Assume 75% pharmacy business in-house
- 20% profit margin = > € 600k profit per annum

Why not Touchstone?

- Lack of opportunity to evaluate model
- Added value appears biased towards Touchstone
- Loss of autonomy
- Lack of scope for expansion etc.
- Targeted at high population high-yield areas
- Creation of monopoly?
- RIPE for corporate buy-out or franchise

Scenarios ?


Publicly Quoted company
Pharmacy Chain
Primary Care Corporation
Drug Wholesaler
GPs (Associates)
Labs & Radiology
Allied HPs (Employees)

“Power tends to corrupt and absolute power corrupts absolutely”

- Lord Acton (1834-1902)

Alternative GP-led Approach

- 6 GPs grouping
- Build 10,000 sq. ft.
- 1,200 sq. ft pharmacy (20 year lease)
- 3,000 sq. ft. for rental to state or AHPs
- Financing over 20 years fully paid from pharmacy lease alone

Summary

- Strategic interests of General Practice served by infrastructure remaining in GP ownership & control
- There must be a level playing pitch if Primary Care Strategy is to be funded privately (fully or partially)
- GPs need to harness the added value they create for pharmacy & others to improve their own infrastructure