Irish College of General Practitioners

ICGP

ICGP Pre-Budget Submission 2019

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Introduction

The Irish College of General Practitioners (ICGP) is the professional body for general practice in Ireland. The ICGP is the representative organisation for education; training and standards in general practice and encourages the highest standards. The College is the recognised body for the accreditation of specialist training in general practice in Ireland and is recognised by the Medical Council as the representative academic body for the specialty of general practice. There are 4,156 Members and associates in the College, comprising over 85% of practising GPs in the Republic of Ireland.

In this year's pre-budget submission, the ICGP has outlined fourteen key recommendations, which we strongly believe are central to the creation of a sustainable cost-effective healthcare service. There is very clearly unequivocal evidence that a well-resourced, general practice-led primary care system is capable of:

a) Managing patients with multiple chronic illnesses (multimorbidity)
b) Curtailing overall healthcare costs

The attached appendices provide detailed insight for each of our recommendations. However, for the last number of years, the College has been strongly advocating for the implementation of a new GP contract and the reversal of FEMPI. This is an overarching priority and action is urgently required on both. In line with this, our recommendations will offer sustainable cost-effective solutions to rising healthcare demand.

Throughout our submission, we reference our theme, *Recruitment, Retention and Replacement*. We are now at a very critical juncture in general practice. The benefits of appropriate and well-resourced funding for general practice are clearly laid out in this submission. To not do so will create irreparable damage to the provision of overall healthcare to the people of Ireland.

Key Recommendations

1. New GP Contract

ICGP recommends the introduction of a new GP contract for general practice as an overarching priority. This should include provision for its review and development as an on-going process, between the Department of Health and GPs. The current capitation-based, GP contract was established in 1989 and does not provide for the care of persons with chronic illnesses. A new contract with a focus on disease prevention and chronic disease management as well as the acute care element is needed as a matter of urgency and we urge the Minister and the government to prioritise same.

2. Community-Based Chronic Illness Management

A comprehensive community-based chronic disease management programme, encompassing the management of patients with multi-morbidity, will reduce healthcare costs and improve patient outcomes. Crucially, it will reduce OPD attendances, reduce Emergency Department visits and increase bed occupancy. This will enable hospitals to focus on secondary care and facilitate necessary capacity for the creation of a single-tier universal healthcare system. This is in line with the ethos and message of Sláintecare. It is stated in Sláintecare that General Practice has a central and enhanced role in integrated and Clinical Care Programmes.

3. Funding General Practice

ICGP recommends resourcing Irish General Practice in line with OECD countries, given historic underfunding and more recent reductions through FEMPI. Irish general practice receives just 2 – 3% of public health expenditure, which compares poorly to 11% in UK. Steps to reverse FEMPI cuts to GMS income must be enabled in Budget 2018/2019 to ensure existing practices can cope with current workload levels and to facilitate the expansion of primary care services in the coming years. Recruitment, retention and replacement in general practice must be appropriately resourced to ensure it can play a pivotal role in the implementation of Sláintecare.

As per the Programme for Government, the ICGP advises that adequate funding be made available for the Postgraduate GP Tutors Network as a key support in enabling GPs to maintain professional standards in patient care and acquisition of knowledge and skills in the rapidly evolving discipline of general practice.

This funding is also needed to accommodate the increase in GPs trying to access this key resource and adopt appropriate modern educational delivery methods.

4. Increasing Capacity in General Practice and Primary Care

Under this heading, the College wishes to address a number of key areas:

Manpower

ICGP can and will work with the government to urgently address manpower shortages in general practice and primary care. The theme of our submission is Recruitment, Retention and Replacement.

In the area of recruitment ICGP is working closely with the Department of Health and the Health Services Executive to increase the recruitment of trainees into the College's 4 year training programme. In the last 4 years we have seen an increase of 50% in the numbers entering. This year 194 trainees entered and the College is committed to increasing the numbers to 250 over the next three years with adequate resourcing. However, recruitment must be aligned with retention. Recruiting our trainees for export is not only disheartening; the cost to the state and to healthcare delivery in Ireland is substantial. Almost 700 GPs are over the age of 60 and will retire in the next 4 years. The HSE has predicted a shortage of 2,000 GPs by 2025. Prioritising the retention of GPs through the provision of an adequately resourced general practice system, which funds chronic disease management, is the most effective mechanism to increase recruitment. A successful new GP contract will reignite further interest in general practice as a viable career in Ireland. Increasing the present number of GPs will require significant investment in general practice to retain our young GPs and attract a return of those who have emigrated abroad.

Practice Nurse supports must be urgently increased to enable community based CDM. This must be performed in the context of the new GP contract, which must ensure that practice nurses are on an equal professional career footing with nursing colleagues in the acute hospital sector in terms of basic pay, sick pay, maternity leave, educational leave, pension and career progression. The ICGP is and will continue to collaborate with nursing training bodies and can provide its expertise to enable the training of necessary additional Practice Nurses.

ICT Capacity and Monitoring Performance

ICGP recommends that ICT costs incurred by GPs, allowing the provision of CDM and embracing new initiatives like ePrescribing should be provided by the HSE. The College recommends negotiation with GPs of an anonymised aggregated data extraction system

(which adheres to GDPR requirements), enabling real time data collection for provision of service development and safety. The advancement of IT solutions, such as summary care records, facilitated with a unique patient identifier, to enable an efficient integrated healthcare system, needs to be prioritised. Investment in IT communication solutions between GP and hospital care can reduce referral rates and overall secondary care costs.

The failure of secondary care to fully computerise is an outstanding weakness in the Irish health system. This matter needs to be urgently addressed by the HSE.

Expanding Built Capacity/Infrastructure in Existing General Practices

To build general practice, ICGP recommends the negotiation, with GPs, of an agreed mechanism to expand built capacity in existing practices. Development of General Practice and Primary Care Teams (PCTs) must be prioritised. Success can be ensured through: a) Liaison with GP representative bodies – as different solutions will be required in different communities; b) Pragmatic research on PCTs considered successful by their participants and dissemination of best practice.

In urban locations, new and establishing GPs should be supported and encouraged to set up new practices through an attractive and innovative start-up package, helping younger GPs build a practice from a zero list.

In rural areas, addressing the inadequacies of the current contract and FEMPI must be prioritised and achieved within the next year to prevent the closure of further rural practices. We have made the same request of Government for the last number of years. We are at crisis point and our hope this will be the last time we have to make such a request of the Government.

Transfer of Discrete Services

Several discrete services are suitable for transfer into general practice teams if adequately resourced, including minor surgery, extended-minor injuries skill set, ENT primary care surgical services (e.g. aural microsuction), joint injections and venesection for haemochromatosis. These activities, must be resourced adequately in general practice to deliver greater volumes of service, at lower cost, coupled with convenience for people in need of these services. This is both a wise investment and good patient care.

5. Building Access to Diagnostic Services

Public patients are unable to access necessary diagnostics in an appropriate timeframe. Some patients are unable to access any diagnostics (e.g.) CT or MRI from general practice.

This results in delayed diagnoses and workload transfer to secondary care. The ICGP recommends the immediate expansion of radiological, cardiac and endoscopic investigations for all patients accessible within general practice. The ICGP views waiting times of greater than six weeks for routine ultrasound, and greater than six months for routine medical OPD as unsafe, and incompatible with international norms for patient safety in developed economies.

6. Medications Management

ICGP recommends inclusion of a medications management programme in the GP contract, enabling safer prescribing and cost savings for the State and individual patients. ICGP is in a position to put in place the educational elements of this, collaborating with the Royal College of Physicians of Ireland and the National Pharmacoeconomics Centre.

7. Building Access to Primary Care and Mental Health Services

ICGP recommends increased numbers of allied primary care professionals, including psychologists, community psychiatric nurses, and occupational therapists into primary care, and improved nursing capacity in communities (Nurses/Health Assistants/Carers). GPs manage the majority of mental health complaints in the Irish State, such as addiction, anxiety and depression. A severe shortage of primary care psychological services in particular is curtailing effective management of these mental conditions and is contrary to the primary aim of the ICGP which is '*to serve the patient*'.

8. Provision of a Termination of Pregnancy Clinical Care Pathway

The ICGP acknowledges the changes that will be required by the outcome of the May 2018 referendum on the repeal of the 8th amendment to the Constitution. As a result of the referendum outcome, a patient-centred clinical care pathway for termination of pregnancy as part of a comprehensive reproductive and sexual health service that is properly resourced will be required in Ireland. The proposed legislation on this matter needs to be accompanied by measures and policies which seek to address and minimise crisis pregnancies, including comprehensive contraceptive services and sexual health education programmes.

Wherever this service is delivered, medical abortions will need to be supervised by doctors with GP training who can provide women with holistic, comprehensive and continuing care.

Ultimately, the service designed to provide this care, needs to address the needs of our patients by reducing the incidence of crisis pregnancy and providing support for it.

9. Promoting Health and Health Promotion

ICGP recommends a government-wide approach on obesity, sedentary lifestyle, problem alcohol use, stress and tobacco. GPs and general practice teams are well placed to address health promotion with patients, given adequate expansion of capacity. Simple distribution of resources based on population or geography is flawed, and healthy lifestyle promotion should reflect the needs of remote and deprived communities.

In addition under this heading, we recommend the following:

- The final passing of the alcohol bill and thus reduce the availability of low-cost alcohol products.
- The enhancement of secondary education programmes, which teach social, personal and health education to adolescents. The importance of addressing increasing sedentary lifestyles needs to be reflected through a broad government coalition, including the Department of Education, Environment, Health and Sport.
- GPs care for marginalised populations. Socially excluded populations include asylum seekers and the homeless. The distribution of resources based on population or geography is flawed; it should reflect the needs of marginalised, remote, deprived and homeless communities.

10. Universal Primary Healthcare

ICGP supports increasing access to general practice and primary care but it is contingent on building capacity in personnel, IT infrastructure and built infrastructure in existing premises.

Expanding access through means testing is the fairest mechanism.

11. Universal Secondary Healthcare

ICGP supports the creation of a single-tier secondary care system, underpinned by principles of solidarity, equity, fairness, efficiency and patient safety. We recommend that an all-party taskforce beset up to work with key healthcare stakeholders to consider either a) a tax-funded, publicly delivered single-tier system, or b) a single payer model (with split in payer and provider functions).

12. Emergency Department Overcrowding

As part of the overall ED taskforce recommendations, ICGP recommends urgent negotiation, with the relevant GP bodies, to establish the contractual basis of chronic disease management programmes.

These would include, but are not limited to, the ability to manage multimorbidity, together with availability of more step-down facilities, enhanced social care in the community, enhanced GP Co-Operative role and development of a Primary Palliative Care Package.

13. Regulation of Private Health Insurers

Private health insurers who wish to operate in the Irish Economy should be required to fully recognise general practice care for relevant aspects of chronic disease management, and end disparate levels of remuneration between GP and hospital provided service items.

14. Reversal of Fragmented Care

ICGP alerts government to the hazards of an increasingly fragmented and commoditised healthcare system. The solution is to insist, build and develop an all-encompassing vision for all members of society which will efficiently deliver the necessary services to all in an equitable, affordable manner which is based on need and proximity to where individuals live.

The ICGP Strongly states that the government must adequately resource effective public general practice and primary care.

Context of pre-budget Submission

General practice is the key to sustainable healthcare. It is recognised since the Alma Ata declaration, that strengthening primary care provides the greatest benefit for health systems and populations over time [1].

Evidence supporting investment in general practice is compelling:

- Adding one GP per 10,000 population reduces mortality, ED visits, inpatient admissions, outpatient visits, surgical activity and health inequalities[2].
- Resourced general practice prevents serious illnesses (cancer and chronic disease)[3].
- Resourced general practice enables early diagnosis of conditions, reducing hospitalisations and unscheduled admissions.
- Over-diagnosis and over-treatment are amongst the largest challenges facing Western healthcare systems, harming patients through excessive testing, unwarranted treatments, & escalating costs[4]. Resourced general practice protects healthcare systems and patients from harms and costs associated with over-medicalisation,[3] particularly those associated with unregulated fee per item specialist care.
- Effective general practice is socially redistributive, increases access to health services and delivers better outcomes for deprived population groups[3].

Why is General Practice Effective?

GPs have a complex, continuing, co-ordinating and central role in healthcare systems. GPs are specialists, following rigorous postgraduate training, examinations and supervision. Irish GPs are sought after globally. ICGP enjoys an excellent international reputation in postgraduate training, and graduates are particularly open to international market forces.

Core Features of General Practice

Continuity of Care

Continuity of care means patients attend the same practice and staff over time. GPs know patients and families deeply, understanding medical history and background. GPs are expert at exploring hidden concerns and unmet needs of patients, leading to tailored, effective and patient-centred care. Continuity is associated with patient satisfaction and efficient use of resources[5].

Coordination of Care

Excessive outpatient (OPD) appointments in the healthcare system cause confusion, poor concordance with treatments, duplication of testing, and care which is essentially ungovernable and stressful for patients. GPs coordinate complex care needs of patients, helping patients navigate a system, which often feels difficult and fragmented. Coordination of care across providers and settings is essential to chronic disease management in particular[6].

The GP performs a *generalist* role, unique among doctors, combining diagnostic and management skills which traverse the boundaries of specialty practice[7]. This allows the GP to integrate the broad scope of general practice with the individual circumstances of the patient (and their family) and guide the patient through the often fragmented world of healthcare[8].

First Contact for Patients in the Healthcare System

GPs are gatekeepers, controlling entry to the secondary system (except in emergency situations)[9]. Costs escalate if GPs are not enabled to gate-keep appropriately.

Comprehensive Care

GPs manage every health problem a patient may bring. GPs can manage the majority of mental health problems in the State; they can treat all chronic illnesses (if resourced), musculoskeletal conditions, paediatric complaints, women’s health, minor surgery etc. Over 90% of presentations to GPs do not require referral to secondary care[10].

Chronic Illnesses and Multimorbidity

The Irish population is aging and living longer. Currently approximately 10% of the Irish population is over 65, increasing to ~25% by 2040[11]. This means sustained increases in the prevalence of chronic illnesses, which the health system will need to prevent and manage optimally.

Chronic illnesses include coronary heart disease, chronic obstructive pulmonary disease, diabetes, arthritis, mental health conditions, the dementias, and major cancers. Chronic illnesses should be managed with community services, led by GPs; this is a key but yet unrealised policy objective of successive governments[12]. The GP contract precludes GPs managing chronic illnesses (diabetes excepted). Chronic illnesses are now managed inadequately in outpatient hospital settings, despite overwhelming evidence this is sub-optimal and that GPs and practice nurses are

willing to take this work on[13].

The present system is ruinously expensive. Each outpatient visit in an Irish public hospital costs ~ €167 per annum. The cost for a GMS patient in general practice for one whole year is €116[14]. This out-dated model overwhelms public outpatient waiting lists and exacerbates ED visitation rates.

'Multimorbidity' is a medical term defined as an individual having two or more chronic illnesses; 65% of patients older than 65 years and almost 82% of those aged 85 years or more have two or more chronic conditions. Patients with multimorbidity include one third of consultations in general practice[15]. International consensus in high performing economies / health systems is that outpatient-hospital management of multimorbidity is prohibitively expensive, unsafe and ineffective.

The View from General Practice

A typical day in general practice consists of the following:

- GPs consult with over thirty-five patients per day.
- GPs also attend house calls and nursing home visits.
- Each consultation generates three problems, two brought by the patient and one identified by the GP[16]. Patients are effectively managed in general practice with onward referral in less than 1:10 cases[10].
- GPs manage growing volumes of administration from a range of agencies.
- GPs review and sign 15-30 repeat prescriptions, most with multiple items.
- Under GP supervision, Practice Nurses see similar numbers of patients, performing phlebotomy (taking blood), cervical smears, dressings, triaging urgent cases and immunising children.
- GPs and Practice Nurses contact many patients daily (or their families, nursing homes or hospitals) to give results or answer queries (by text/ phone/ email).

A Typical Patient in General Practice

The following de-identified real case study is a typical patient cared for in general practice.

Case Study

- Mary Smyth is 67 years old and has a medical card.
- Living alone in a deprived inner-city community, her husband died of lung cancer (2015).
- Her GP emigrated to the UK two years ago. Nobody has applied for this list since, and she now receives care from locum GPs.

Mary suffers from *eight* chronic illnesses (*multimorbidity*).

a) She has several cardio-metabolic conditions.

   Mary has high blood pressure (2001) and type 2 diabetes mellitus (2006). She does not attend hospital for appointments, leaving her diabetes poorly controlled. She had a heart attack (2011), with two stents inserted into her coronary arteries. She was diagnosed with an irregular heart rate (atrial fibrillation) (2013), and now takes a blood thinner (warfarin). She has an underactive thyroid (2006).

b) She has a chronic respiratory disease.

Mary smoked for thirty years and has a respiratory condition called chronic obstructive pulmonary disease (COPD) (2005). Her GP encouraged her to quit smoking at the time of the heart attack.

c) She is in constant pain.

She has osteoarthritis of her hands, knees, hips and lumbar spine. She was referred one year ago for an orthopaedic appointment for hip replacement, but is still on the waiting list for the initial appointment.

d) Mary suffers from significant mental health difficulties.

Mental health difficulties include anxiety and depression, relating to difficult psychosocial circumstances (one son in jail, two other children addicted to heroin).

Medications

Mary takes thirteen regular long-term medications, requiring regular monitoring and review by her GP.

- Aspirin (for heart disease)
- Atorvastatin (for heart disease)
- Ramipril (for high blood pressure, diabetes and heart disease)
- Bendroflumethiazide (for high blood pressure)
- Bisoprolol (for high blood pressure and heart disease)
- Warfarin (for atrial fibrillation)
- Metformin (for diabetes)
- Gliclazide (for diabetes)
- Buprenorphine patch (an opiate patch medication, for pain)
- Paracetamol (for pain)
- Topical anti-inflammatory (for pain)
- Thyroid hormone (for underactive thyroid)
- Inhalers X 2 (for chronic obstructive pulmonary disease)

Healthcare Utilisation

a) General Practice

Mary attends her GP approximately ten times per year, usually for infective exacerbations of her bronchitis, for pain and mental health difficulties. With her GP emigrating recently and rising waiting lists, it now takes over one week before Mary can get an appointment to see a GP.

b) Hospitals: Outpatients

Mary had 21 appointments at two local hospitals in 2015 – she frequently misses appointments. She attends nine outpatient services (between two different hospitals), including cardiology, diabetes, orthopaedic and respiratory OPDs. She required twelve blood tests each year for warfarin alone.

Public OPD clinics (often run by Junior Hospital Doctors) order X-rays and bloods, frequently duplicating tests, which is very frustrating for Mary.

She often misses hospital clinics, citing the cost of a taxi and seeing "a different doctor every time". She has missed her diabetes and respiratory appointments in the last two years.

Hospitals: Emergency Department

Mary attended the local Emergency Department twice this year with infective exacerbations of her chronic obstructive pulmonary disease, being unable to obtain timely appointments with her GP (cost of unscheduled ED admissions is estimated at £3,200 per admission in the NHS).

As we can see from the above, Mary, a 67-year-old woman is living on her own in the community with significant medical and social problems without the supports required to enable her safe continuation of living at home. Her medical care is disjointed and substandard due to the many different problems outlined above. As a result of this lower than desired standard of medical care in the community and in the hospital setting, Mary has required a number of acute admissions due to acute relapses of her illness that were otherwise eminently preventable and avoidable. Her medications require rationalisation and review, her medical care requires integration between hospital services and the GP led community services. Her GP service needs to be resourced and stabilised. Without these improvements and supports Mary will no longer be able to continue living safely in her own home in the community where she has lived all her life.

Appendix 1: Challenges for a Sustainable Healthcare Service

There are several challenges, from a general practice perspective, in delivering a sustainable healthcareservice. ICGP has outlined cost-effective solutions for each challenge below.

1. New GP Contract

The current capitation-based, GP contract was established in 1989 and does not provide for the care of persons with chronic illnesses.

The ICGP recommends the introduction of a new contract for general practice as an overarching priority, including provision for its review and development in an on-going process between the Department of Health and GPs.

2. Chronic Illness Management

Chronic illnesses are poorly managed in Ireland, with excessive costs from hospital outpatient visits, increases in waiting lists, rising ED visits (from uncontrolled chronic illnesses), worse outcomes for patients and poor medication management[2].

In the case study above:

- Mrs Smyth is unable to have her chronic illnesses managed by her GP because there is no provision in the GP contract, except for diabetes.
- Mary attends two different hospitals for nine annual outpatient appointments as well as attending hospital on twelve occasions for blood tests. All of these visits could take place in general practice.
- Mary misses hospital-based appointments. She cannot afford a taxi, is chronically unwell and depressed.
- Mary's chronic illnesses are not well controlled (such as her chronic obstructive pulmonary disease), and as a result she gets exacerbations of her illness, and attends the Emergency Department.

It is internationally recommended that chronic illnesses should be managed in general practice through structured properly resourced chronic disease management programmes[17].

Recent evidence states that patients with multiple chronic illnesses receive conflicting advice, duplicated investigations and unnecessary medications when *single* disease guidelines are applied to their care. The focus needs to be on management of

multimorbidity, rather than using single disease protocols as part of chronic disease management. Mary's nine hospital outpatient visits and multiple phlebotomy appointments could be incorporated into a GP-led chronic disease management programme. Visits could be consolidated and reduced in a generalist service, allowing Mary to be treated closer to home, in a patient-centred manner. In this way, managing patients with multiple chronic conditions (multimorbidity), like Mary, in a person-centred manner can be facilitated in general practice, in accordance with best evidence[18].

ICGP has repeatedly demonstrated GP-delivered, peer-reviewed clinical evidence to support the requirement for the Government, DoH and HSE, to properly focus on the prioritisation of primary care and General Practice as the solution to Ireland's problems in dealing with Chronic Disease Management (e.g. Heartwatch[19]). Up to 2014, ICGP was engaged with the HSE Clinical Care Programmes, and developed models of care and guidelines to support Ireland's main chronic diseases (diabetes, heart failure/ CAD, COPD, asthma and mental health).

In particular, most mental health conditions are treated within the general practice setting. Addiction, anxiety, depression and stress can all be effectively managed, with supports from primary care colleagues, and our colleagues in secondary care, when required. ICGP welcomes the introduction of a Diabetes Cycle of Care in October 2015 as a first step towards moving chronic disease management to the community. This has been further enhanced by the appointment of a Clinical Lead in Diabetes.

The stumbling block for roll out of these clinical models is the underfunding of primary care infrastructure. ICGP supports developing integrated care programs, particularly since the appointment of a GP as National Primary Care Lead. To ensure the success of general practice-based chronic disease management programs, GPs will need to have an enhanced, central role in future Clinical Care Programmes and we welcome the appointment of four Clinical Leads in Asthma, COPD, Diabetes and Cardiovascular within the College.

High quality training, research and continuous medical education (CME) enable continuous quality improvement in the health sector. CME for GPs and Practice Nurses needs to be enhanced to meet future healthcare and regulatory requirements. This is best achieved by a collaborative approach between ICGP and Government. Research is essential for health system development, enabling analysis of workforce planning, enhancing quality and safety, researching prescribing and patient outcomes. Enhanced government funding of primary care research, with structured career pathways for GPs, Nurses and other primary care professionals wishing to pursue patient-outcome focused research interests, would deliver value for investment.

ICGP supports advancement of the role of GPs with special interests, aligning themselves with agreed priority areas (e.g. clinical programmes, minor surgery and minor injury programmes). These GPs with special interests require their service to be properly resourced and funded.

Solutions

- ICGP recommends the urgent negotiation, with the relevant GP bodies, to establish the contractual basis of chronic disease management programmes, which will recognise the comprehensive management of multimorbidity and mental health conditions.
- General Practice should have a central, enhanced role in Integrated Care Programmes and Clinical Care Programmes.

3. Funding Deficits in Irish General Practice

Irish general practice is under-funded compared with OECD nations.

Government spends just over 2-3% of the health budget in general practice, compared to 11% in the UK[20]. The 'business model' of modern Irish general practice is becoming increasingly dysfunctional.

FEMPI legislation has removed over 30% of government income for GMS services, which is crippling general practice, limiting the care patients receive and adding to difficulties in recruiting and retaining GPs. A sustainable healthcare service necessitates investment in general practice.

Solutions

- ICGP recommends resourcing Irish general practice in line with OECD countries.
- ICGP requires that the impact of FEMPI cuts in general practice is practically recognised and addressed.

4. Personnel Capacity: GP and Practice Nurse Capacity in Irish General Practice

Ireland has low numbers of GPs per head of population compared to many OECD countries[21]. The aging GP workforce, low numbers of postgraduate training places for GPs, and failure to retain young GPs all contribute. Failure of retention is driven by aggressive recruitment of Irish GPs internationally, an out-dated and inflexible GP

contract, and the realisation that inequity and inefficiency in the present Irish health system are incompatible with the practice of good medicine. Further, established GPs are now beginning to leave mid-career[22].

GP Training

The ICGP embraces the transfer of GP training to the ICGP (HSE SLA with ICGP) and recommends increasing capacity of the National GP Training Programme during the next 3-5 years to meet the projected increases in demand based on population demographics.

The ICGP recommends development of multidisciplinary postgraduate training of specialist GP Trainees, nursing graduates and Practice Administrators.

Recruitment and Retention

Training GPs, only to see them emigrate to other health systems, is not cost effective. The continued failure to retain our GPs will further erode and prevent the creation of a sustainable primary care-based healthcare system in the future. Recruitment and retention of GPs begins with the provision of an adequately resourced general practice system. Many younger GPs emigrate to work in healthcare systems where there are comprehensive chronic disease management programmes and no delays in accessing diagnostics. Engaging with emigrated and emigrating GPs and evaluating their reasons to stay/ return must be a priority of government to address this brain drain.

ICGP published a report in 2015 highlighting that only one third of current GP trainees are confident enough in their futures in the Irish health system to consider staying in Ireland[23]. Viability of general practice in Ireland (20%) and financial prospects (36%) are the two main reasons cited for leaving.

Areas of Deprivation

The above case of Mrs Smyth highlights what is happening in areas of deprivation. It is a direct example of Julian Tudor Hart's Inverse Care Law: *"The availability of good medical care tends to vary inversely with the need for it in the population served. This ... operates more completely where medical care is most exposed to market forces.[24]".* Evidence highlights the association between socio-economic deprivation and poor health. One in four practices in Ireland are located in deprived communities.

Practices in deprived communities have differing financial, personal, professional and educational needs. A fundamental solution to prevent health inequalities, glaringly evident in deprived communities, is strong, well-resourced general practice / primary care.

It is difficult to recruit new GPs to work in areas of deprivation because it remains financially penalising and professionally challenging. Deprived areas have fewer GPs making it more difficult for patients to access services. Nationally, there is one GP per 1,600 of population (less than the OECD norm). In North Dublin, for example, there is one GP per 2,500 population.

Rural General Practice

A second 2015 ICGP Report ("*A vision for the future of Rural General Practice*") highlighted challenges facing rural general practice. Rural GMS lists remain vacant. Substantial cuts in top line payments (FEMPI) and discontinuation of rural distance codes have rendered rural practice non-viable.

The Rural Practice Allowance (RPA) is an essential support for rural general practice and restoration of this allowance would be a very welcome first step. ICGP recommends additional financial, educational and professional supports, highlighted in this ICGP report[25].

Out of Hours

Out of Hours (OOH) services are under pressure to maintain care with rising attendances in recent years, exacerbated by introduction of the Under 6s contract.

ICGP recognises the potential of GP Co-operatives and recommends that they are supported by expanding roles in minor injuries management; co-ordinating care with CITs; augmenting primary palliative care; supporting day time general practice with overflow clinics; locum placements and complaints management. All of these additional elements are underway in individual co-operatives and directly assist in addressing pressing issues in both general practice and the health system. These activities enable more care in the community at reduced cost, with higher patient acceptability and satisfaction.

Practice Nurses

There are currently approximately 1,700 practice nurses working in general practice and many work part time. To meet demand in chronic disease management, ICGP also recommends additional full time Practice Nurses equivalents. ICGP asks the government to work with the ICGP and relevant nursing training bodies to address this issue.

Solutions

- ICGP recommends government address the recruitment and retention of newly trained GPs as a matter of urgency.
- ICGP requests government to work with ICGP and relevant nursing training bodies to provide more GPs and practice nurses to meet future workforce planning requirements.

5. ICT capacity and monitoring of performance

National GP Dataset/ IPCRN/ Monitoring Quality

Chronic disease programmes require assessment of efficacy. Given the structure of GP electronic medical records systems, this is set up but not used in the Irish system. We recommend the use of anonymised aggregated datasets (agreed by GP representative bodies). This involves real-time capturing, monitoring and feedback to guide performance and development. The Irish Primary Care Research Network (www.ipcrn.ie) has been developed as a real-time method of data analysis based on use of agreed coding. IPCRN involves collaboration between ICGP and academic partners (NUIG, AUDGPI, HRB Centre for Primary Care Research (RCSI)). This collaboration can now easily deliver, with the HSE, a high quality evolving real-time dataset, based on detailed activities of GPs, Practice Nurses and Practice Administrators.

Integrated Health Records

ICGP recommends each patient has a single electronic medical record, accessible to them, held and managed by their nominated GP, shared by their GP with allied agencies, as required and consented.

ICGP recommends that all health professionals maintain clinical notes on electronic records.

The costs of implementing new IT infrastructure, and ongoing maintenance, require adequate resourcing by government, in agreement with GP representative bodies. ICGP recommends the continued involvement of the GPIT group, with the HSE and DoH, in national IT projects and eHealth Ireland, to ensure integration of health records.

Solutions

- ICGP recommends negotiation, with GPs, of an anonymised aggregated data extraction system, enabling excellence in health services research and monitoring thus ensuring quality and safety.
- ICGP requests urgent provision of integrated national electronic health records.

6. Built Capacity

There are over 25 million GP consultations per annum in Ireland[26]. This will increase given expansion of GP/ Practice Nurse activities from chronic illness management, and increasing access provided by expanding PCRS eligibility. Physical capacity of GP surgeries to address workload requires expansion. Government and GP organisations must collaborate to ensure resources and arrangements to enable augmentation of GP capacity grow in line with patient need.

The ICGP supports GP involvement in primary care teams (PCTs)[27]. PCTs do not need to be geographically co-located. Constructing primary care centres without involvement of local GPs does not mean a PCT care team is functional. It is a top-down approach to policy implementation, which at present only appears to work sporadically[28].

Solutions

- To enable the expansion of primary care and general practice capacity ICGP recommends development with GPs of a range of agreed mechanisms to expand capacity in all existing practices.
- Primary care teams must be prioritised. The most effective ways to ensure their success is to:
    a) Liaise with GP representative bodies - because different solutions will be required in different locations and the construction of large centres is not always required.
    b) Conduct pragmatic research on PCTs, which are considered by their participants to be successful.

7. Medications Management

In 2014, the cost of the community drugs bill was €1.1 billion, including payments to pharmacists. As an example, this compares poorly to the overall GMS payment to GPs in 2014 which was €428 million[14] (proportionally five times less than the UK).

For patients like Mrs Smyth in the above summary case, biannual reviews by GPs of medications are recommended[18].

The ICGP recommends that Government liaise with GP organisations to establish medication review structures as integral to GP contracts.

Solution

- The ICGP recommends immediate development of a medication management element in the GP contract, enabling safer prescribing and savings, based on an expanded Preferred Medicine Scheme, coordinating with Integrated Care Programmes and the National Pharmacoeconomics Centre.

8. Building Access to Diagnostic Services

For radiological (e.g. CT and MRI) and cardiac (e.g. echocardiography) investigations, GPs do not have effective access for public patients. GPs must therefore refer patients to Outpatient Departments or Emergency Departments. This is wasteful of OPDs, EDs, it compounds delays and represents a clear level of medical risk for public patients in delayed diagnoses.

The 2016 ICGP report *'Access to Diagnostics Used to Detect Cancer'* highlights the lack of access to tests for cancers, which can lead to delays in diagnosis, predominantly for public patients[29]. Delayed diagnoses lead to worse outcomes for public patients, increasing costs, with a consequent need for more invasive / expensive treatment, of more advanced disease[29,30]. A recent UK study demonstrates the increased costs regarding comparative costs of treating Stage 1 versus Stage 4 colorectal carcinoma[30].

A uniform national standard waiting time for key investigations needs to be implemented against which services can be benchmarked, based not on incremental improvement on historic performance, but on neighbouring health systems. For example:

Routine endoscopy:	12 weeks
Urgent endoscopy:	3 weeks
Routine ultrasound:	6 weeks
Urgent ultrasound:	2 weeks
Routine OPD appointment:	12 weeks
Urgent OPD appointment:	2 weeks

Solutions

- The gap in access between public and privately insured patients for diagnostics requires closing.
- Independent analysis of public radiological, cardiac and endoscopic investigations against independent / international standards, and system wide adoption of national standard waiting times.
- ICGP recommends development of free standing diagnostic facilities.

9. Building Access to Primary Care Services

Primary care staff: GPs experience difficulties for both GMS and private patients, relating to referral to primary care services. For GMS patients, there can be inordinate delays in referrals to certain services (e.g. long waiting lists for physiotherapy), resulting in clinical deterioration, and in requirement to refer to OPD. Many non-GMS patients have no access to public primary care services and must pay the full costs of seeking primary healthcare (e.g. attending a private physiotherapist).

Primary care teams: GPs must be enabled to attend multidisciplinary meetings. Currently, this is largely impossible, and the inability of GPs to engage meaningfully with primary care teams is a major block to efficient and effective care.

GPs manage the majority of mental health complaints in the Irish State (addiction, anxiety, depression). A severe shortage of primary care psychological services in particular is curtailing effective management of mental health conditions.

Solution

- ICGP recommends the expansion of allied primary care professionals, including psychologists, community psychiatric nurses, and occupational therapists in primary care, together with effective engagement and involvement of GPs in primary care teams.

10. Unfair Access to Secondary Care

The discrepancy in access to secondary care, if highlighted as a whole system phenomenon, arguably could precipitate a social / political crisis. The ICGP has long campaigned for a single-tier access for patients to secondary care services. This requires remodelling of funding of Irish healthcare.

Solution

- ICGP requests the creation of a single-tier healthcare system, with principles of solidarity, equity, fairness and efficacy.

11. Initiatives to Empower GPs to Assist in Reducing Hospital Overcrowding

The ED Overcrowding Taskforce recommends reduction in ED Overcrowding, through increasing bed capacity, improving community supports and improving step down facilities[31].

Well-resourced general practice also reduces unscheduled ED visits. A functioning chronic disease management programme will enable general practice to reduce ED visitations and healthcare costs, if undertaken with improved step-down facilities and community care packages.

GP Co-Operatives have the potential to assist in addressing the ED overcrowding problem. This could be achieved by augmented roles in minor injury management, integration with CITs (Community Intervention Teams) and working more closely with ED Departments, in planning, selective use of Co-Op colocation in ED Departments and the provision of sessional GPs in EDs.

Provision of an effective Primary Palliative Care Package will enable the delivery of more end-of-life care in communities, avoiding unwelcome over medicalisation of end of life, presently a cause of inappropriate, unnecessary acute admissions.

Solution

- As part of the overall ED taskforce recommendations, ICGP recommends the urgent negotiation, with the relevant GP bodies, for the establishment of the contractual basis of chronic disease management programmes. This would include the ability to manage multimorbidity, together with availability of more step-down facilities, enhanced social care in the community, enhanced GP Co-Operative role and development of a Primary Palliative Care Package.

12. Health Promotion and Public Health

The ICGP supports Healthy Ireland, the national framework to improve health and wellbeing of the people of Ireland. GP teams are the point of first/ continuing contact in healthcare, and well placed to systematically address unsafe alcohol and tobacco use, stress, obesity and sedentary lifestyles.

Strong evidence supports consistent brief interventions to address the key lifestyle risk factors for serious illness ie smoking, alcohol abuse, obesity, sedentary lifestyle addressing these risks. Given resource contraction in general practice, prevention potential is only partially exploited at present. Addressing resource deficits in primary care together with a multi departmental government approach represents the optimal direction in addressing key public health challenges facing Irish society.

Solutions

- ICGP recommends a government-wide approach to obesity, sedentary lifestyle, problem alcohol use, stress and smoking to address the challenges in promoting good health.
- GP teams require resources to address health promotion with patients, to build capacity and deliver on the Healthy Ireland framework.

13. Fragmentation of Care

Continuity of care is key to managing complex patients. In our example above, Mrs Smyth's care is fragmented and her GP service is now compromised. GPs and public patients' first-hand experience is of an increasingly complex secondary healthcare environment, with multiple corporate healthcare providers attempting to deliver care with potentially deleterious effects for patients and broader society.

The ICGP formally alerts government to costs and dangers of fragmented care and a corporate 'for profit' environment of modern healthcare.

The ICGP strongly cautions against the negative effects of corporatization in general practice, which has begun in Ireland. This trend will affect younger, establishing GPs disproportionately, dissuaded from practicing in Ireland as Principal GPs, with corporate companies filling the gap. Young, establishing GPs need to be supported and incentivised to take up Principle GP positions, not demoralised into taking salaried jobs for profit-making companies.

Solutions

- Adequately resource effective public general practice and primary care.
- ICGP alerts government to the hazards of an increasingly fragmented and commoditised healthcare system. The solution is to insist, build and develop an encompassing vision for all members of society, efficiently delivering necessary services to all, in an equitable affordable manner, based on need and proximity to where individuals live.

Appendix 2: Six 'Quick Wins' for Irish Society

1. Payment must cease to be a barrier to essential medical care
2. Universal use of electronic medical records
3. Build capacity in primary care
4. Fully establish chronic disease management in primary care
5. Support end-of-life care in the community
6. Health insurers must understand and appreciate the quality and high standards of GP Led Primary Care in the Community and fund it appropriately.

References

1. WHO. *Declaration of Alma- Ata.* 1978.[Online] Available at: http://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf [Accessed 28th August 2018]
2. Starfield B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012. *Gac Sanit.* 2012 Mar; 26 Suppl 1:20-6. doi: 10.1016/j.gaceta.2011.10.009. Epub 2012 Jan 21.
3. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005; 83(3):457-502.
4. Moynihan R, Doust J, Henry D. Preventing overdiagnosis: how to stop harming the healthy. *BMJ.* 2012 May 28; 344:e3502. doi: 10.1136/bmj.e3502.
5. Hill AP, Freeman GK. *Promoting Continuity of Care in General Practice.* RCGP Policy Paper. London: The Royal College of General Practitioners; 2011.
6. Rothman AA, Wagner EH. Chronic illness management: what is the role of primary care? *Ann Intern Med.* 2003 Feb 4; 138(3):256-61.
7. McKee M, Nolte E. Responding to the challenge of chronic diseases: ideas from Europe. *Clin Med (Lond).* 2004 Jul-Aug; 4(4):336-42.
8. Phillips WR, Haynes DG. The domain of family practice: scope, role, and function. *Fam Med.* 2001 Apr; 33(4):273-7.
9. Forrest CB. Primary care in the United States: primary care gatekeeping and referrals: effective filter or failed experiment? *BMJ.* 2003 Mar 29; 326(7391):692-5.
10. Gouda P et al. Treat or refer? Factors affecting GP decisions. *Forum: Journal of the Irish College of General Practitioners.* 2013 Aug; 30 (8): 10-12.
11. IMO. *Solving the Chronic Disease Problem through General Practice.* Dublin: Irish Medical Organisation; 2016.
12. Department of Health & Children. *Tackling Chronic Disease. A Policy Framework for the Management of Chronic Diseases.* Dublin: Department of Health and Children; 2008.
13. Darker C, Whelan L, O'Shea B. *Chronic Disease Management in Ireland: Perspectives from Patients and Clinical Stakeholders- implications and recommendations for the Irish healthcare system.* Dublin: Department of Public Health & Primary Care, Trinity College Dublin and The Adelaide Health Foundation; 2015.
14. HSE. *Primary Care Reimbursement Service: Statistical analysis of claims and payments 2014.* Dublin: HSE; 2014.
15. Barnett K, et al. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet.* 2012 Jul 7; 380(9836):37-43. doi: 10.1016/S0140-6736(12)60240-2. Epub 2012 May 10.
16. Salisbury C, et al. The content of general practice consultations: cross-sectional study based on video recordings. *Br J Gen Pract.* 2013 Nov; 63(616):e751-9. doi: 10.3399/bjgp13X674431.

17. RCGP Written Evidence: Health Select Committee Inquiry on Management of Long-Term Conditions. London: The Royal College of General Practitioners; 2013. [Online] Available at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/long-term-conditions.aspx [Accessed 28th August 2018]
18. Wallace E, et al. Managing patients with multimorbidity in primary care. *BMJ.* 2015 Jan 20; 350:h176. doi: 10.1136/bmj.h176.
19. O'Riordan M. Chronic disease care – redressing the balance. *Forum: Journal of the Irish College of General Practitioners.* 2015 Mar; 32 (3): 16-17.
20. ICGP. Pre-Budget Submission 2015. Dublin: Irish College of General Practitioners; 2015. [Online] Available at: https://www.icgp.ie/go/library/catalogue/item/5F92634A-B5A0-F573-848D76D9F4D72662 [Accessed 28th August 2018]
21. Oireachtas Library and Research Service. GPs and the Irish Primary Care System: towards Universal Primary Care? Spotlight No. 1. 2014. [Online] Available at: https://webarchive.oireachtas.ie/parliament/media/housesoftheoireachtas/libraryresearch/spotlights/primary_care_spotlight_154558.pdf [Accessed 28th August 2018]
22. O'Kelly, M, et al. *Structure of General Practice in Ireland: 1982 - 2015.* Dublin: ICGP and Trinity College; 2016. [Online] Available at: https://medicine.tcd.ie/public_health_primary_care/assets/pdf/structure-of-general-practice-2016.pdf [Accessed 28th August 2018]
23. Mansfield G, et al. *Bridging the Gap: How do GP Trainees and Recent Graduates identify themselves as the future of Irish GP Workforce.* Dublin: Irish College of General Practitioners; 2015.
24. Hart JT. The inverse care law. *Lancet.* 1971 Feb 27; 1(7696):405-12.
25. O'Riordan M. *ICGP vision for the future of Irish Rural General Practice.* Dublin: Irish College of General Practitioners; 2015.
26. Behan W, Molony D, Beamer C, Cullen W. Are Irish adult general practice consultation rates as low as official records suggest? A cross sectional study at six general practices. *Ir Med J.* 2013 Nov-Dec; 106(10):297-9.
27. O'Riordan M. *Primary Care Teams: A GP Perspective.* Dublin: Irish College of General Practitioners; 2011.
28. Cullen P. Delays to 35 out of 36 planned primary care centres. *Irish Times*, August 2nd 2016. [Online] Available at: https://www.irishtimes.com/news/health/delays-to-35-out-of-36-planned-primary-care-centres-1.2741670 [Accessed 28th August 2018]
29. O'Shea MT, Collins C. *Access to Diagnostics Used to Detect Cancer.* Dublin: Irish College of General Practitioners; 2016.
30. Incisive Health, Cancer Research UK. *Saving lives, averting costs: An analysis of the financial implications of achieving earlier diagnosis of colorectal, lung and ovarian*

cancer: a report prepared for Cancer Research UK. Oxford: Cancer Research UK; 2014.

31. HSE. Emergency Department Task Force Report. Dublin: Department of Health; 2015. [Online] Available at: https://health.gov.ie/blog/publications/emergency-department-task-force-report/ [Accessed 28th August 2018]