The Irish College of General Practitioners

THE FUTURE ORGANISATION OF GENERAL PRACTICE IN IRELAND

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FOREWORD

This document had its origins in previous policy documents produced by the College, particularly those in reponse to the (so-called) Tussing Report and to the G.M.S. Working Party Report. It was the latter I.C.G.P. Report ("Proposals for a Modified Fee and Standards of Practice–A Discussion Document") which directly gave rise to the formation of a Policy Working Group at the meeting of Council in September, 1985. The original members of that group appointed by Council were Dr. Michael Boland (Chairman, West Cork), Dr. Ger Kidney (Laois/Offaly), Dr. Owen Clarke (Meath), Dr. Harry Comber (Cork City), Dr. James Drynan (Kilkenny), Dr. Cormac Macnamara (Waterford), Dr. Declan Murphy (Kilkenny) and Dr. Seamus O'Beirn (Galway), who was co-opted on to the group at its first meeting.

By May, 1986, the Group had produced a first draft report which was subsequently re-drafted in August, 1986 and presented to Council in September, 1986. Council recommended a number of changes and the Draft Document was substantially modified by the original working group, together with two extra co-opted members; Dr. Sean O'Brien (West Dublin) and Dr. Liam Lacey (West Dublin). The final version of the Discussion Document was publicly launched at a Press Conference in the Royal College of Surgeons and mailed to all members of the College in October, 1986. Local Faculties were asked to discuss the Document and return written comments by February, 1987. Meanwhile preparations were made to have a plenary session at the A.G.M. in Galway, in May, 1987, devoted to discussion of the document. Responses from the Faculties indicated the main areas where difficulties or disagreements were arising, and this formed the basis for the format of the A.G.M. session. On the Saturday afternoon (May 9th, 1987) in Galway, a small-group workshop involving over 120 members of the College discussed and voted on the principal points of the document. These decisions were formally confirmed at the A.G.M. Business Session on the following day. As a result of this action a Re-Drafting Group was appointed by the new Council, with the task of re-drafting those parts of the document which had not been adopted as policy. The members of this group were Dr. Michael Boland (West Cork), Dr. Harry Comber (Cork City), Dr. Ger Kidney (Laois/Offaly), Dr. Conal O'Doherty (Wexford), Dr. Garrett Hayes (West Dublin), Dr. Declan Murphy (Kilkenny), Dr. P.J. Henry (Sligo), Dr. Eamon Faller (Galway) and Dr. Niall McGauran (West Midlands).

The document which is now before you represents those parts of the original Discussion Document which had been accepted and adopted as College policy at the Galway A.G.M., together with the re-drafted sections (principally Chapter 5). It is intended to present this final amended document to the forthcoming A.G.M. in Cork on 22nd May, 1988, with a view to adoption as policy.

Although this document was written by a relatively small number of College

members, the views expressed are the end result of a widespread and ongoing debate about the nature of General Practice. This debate has been conducted through the wider activities of the College both, nationally and locally, and in that sense every College member had contributed in some way to this final expression of policy. Nevertheless, this is inevitably a consensus document, and none of us believe or expect it to be totally acceptable to every member. Neither is it the last word on College policy. It should be seen as just one step on a continuing path of developing and even changing policy in response to altering circumstances.

Finally, two names should receive special mention. Fionán Ó'Cuinneagáin joined the College as Administrative Secretary in January, 1986, at about the same time as the formation of the original Working Group. As with everything else, his professionalism, commitment and efficiency has been absolutely vital in assisting and supporting the development of the document. Ultimately, the document is primarily a monument to the vision and determination of Michael Boland, who was Chairman of Council at the time.

Many other people helped in a variety of ways. To all of them we offer our sincerest thanks and appreciation.

Declan Murphy
Chairman of Council
March 1988

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SUMMARY OF PRINCIPAL RECOMMENDATIONS

INTRODUCTION

This document is part of the evolving policy of the Irish College of General Practitioners on reform of our health care system. It considers two questions:

(a) How can general practice be organised in the future so that, while remaining cost effective, it can deliver an enhanced quality of service to patients?
(b) What should be its role in the overall context of the health service?

By the organisation of general practice we mean, not just the settings, equipment and staff, but all aspects of the medical care system which relate to General Practitioners. Thus it includes the timing, range, extent and quality of the services offered. It involves the competence and professional values of individual doctors. It also includes the numbers and distribution of all General Practitioners, the manner in which they enter practice, and the training and education they receive.

In considering each area of general practice the document follows a standard format. We have first examined the present state of the system and have then tried to identify the reforms which we would regard as priorities. Finally, we have suggested strategies to be used to bring about the sort of changes which we think are required.

GENERAL PRINCIPLES

Equity and Uniformity

The College supports the present uniformity in the quality and delivery of care by General Practitioners to all patients irrespective of their category and eligibility. (3.1)

We believe that patients should also enjoy uniform standards in hospital care. (3.2)

We support the concept of equity in the amount and distribution of resources, and

believe that Category II eligibility should be based on family income and size rather than on the individual earnings of the head of the household. (3.3)

Patients' Choice

Irish patients have (and exercise) choice of General Practitioner. We support this fundamental element of our system and regret its increasing disappearance from the hospital sector. (3.4)

Source of Motivation

The emphasis in this document on financial incentives should not be taken as indicating that the College believes these to be the only or even the most important sources of motivation for doctors. However, as general practice is now organised there is little or no financial incentive to quality practice. Indeed there are disincentives, because the doctor who invests in his premises, staff, equipment, records and organisation, and even in his own training and continuing education usually earns less as a result. (3.9)

As a general principle we recommend that incentives rather than penalties should operate throughout the system. It should discriminate in favour of those doctors who invest in their own skills, in improvements to their practices, and in the range of services offered. Such incentives should also become an instrument of policy to be used as necessary in those areas of practice considered by Government and the I.C.G.P. in consultation, to be in need of development. We advocate the principle of a performance sensitive contract. (3.10)

Patient Incentives and Eligibility

We recommend that greater attention be paid to patient incentives. Thus steps must be taken to ensure that the position which pertained until recently whereby attendance at hospital was cheaper for most patients than a visit to their General Practitioner, must not be allowed recur. (3.11)

The Extent of Government interest in General Practice

General practice as a whole cannot be considered in isolation from the hospital services, particularly in any consideration of the cost effectiveness of health spending. (3.13)

TRANSFER OF CARE AND RESOURCES FROM THE HOSPITAL SECTOR

The explosive inflation of health costs are largely attributable to the acute general hospital sector and its rapid expansion in the last ten years. In spite of public pronouncements to the contrary, community services have been relatively starved of funds.

Priorities for Reform

We recommend that a reversal of these trends must be the priority in health care

planning. There should be a sustained effort to transfer care from the hospital to the community. (4.4)

Strategies for Change

Make general practice the setting of choice for prevention and screening services. (4.5)

Create incentives for General Practitioners to retain clinical responsibility rather than refer. (4.5)

Provide incentives for the longer consultations required to manage certain conditions without referral. (4.5)

Provide incentives for those who acquire and use special skills. (4.5)

Create incentives for all patients to attend their General Practitioner rather than the outpatient/accident and emergency department of their local hospital. (4.5)

Enable and encourage referral between General Practitioners. (4.5)

Remove the barriers which prevent direct access by General Practitioners to services such as X-ray, laboratory, day care, physiotherapy and psychology services, on behalf of their patients. (4.5)

Invest in general practice record systems (4.5)

Encourage everyone to nominate or register with a General Practitioner. (4.5)

Create incentives to investment in general practice premises, staff and equipment. (4.5)

Invest in the Primary Care Team. (4.5)

Discourage follow up visits in accident and emergency departments and outpatients departments. (4.5)

Enable earlier discharge from hospital. (4.5)

Establish combined care committees of General Practitioners and Consultants. (4.5)

Appoint more Consultants with smaller Non Consultant Hospital Doctor (NCHD) teams. (4.5)

Plan a gradual reduction in all hospital staffing levels. (4.5)

Create incentives for Consultants to 'consult' outside the hospital setting at the request of General Practitioners. (4.5)

Develop proper geriatric care services. (4.5)

Encourage a positive attitude to the home care of terminal illness. (4.5)

Invest in general practice training and retraining, and expand and reward, continuing education and performance review. (4.5)

Re-educate the public thereby revising patient attitudes to and demands for the most expensive hospital care. (4.5)

Do not set up special primary care clinics to correct deficiencies in existing areas unless it can be clearly shown that general practice, with appropriate assistance, is incapable of providing them. (4.5)

We recommend that there must be a comprehensive medium term plan and an end to year-to-year financial uncertainty. That plan must include all the hospital and community services. The organisation of the latter service must be reformed to include the General Practitioner. (4.7)

THE BASIC SERVICE FOR EPISODIC ILLNESS

Systems of Payment

Characteristics of the present fee per item system

Under the present system Irish General Practitioners receive a global fee per item of service either from patients directly or from the Government on their behalf. This fee is intended to include everything and is paid irrespective of the standard of service offered. (5.2)

It is a fault of the present Irish fee per item of service system that the General Practitioner's income depends solely on the number of face to face consultations which can be fitted into each day. It may lead to medicalisation of minor illness and induce an unhealthy doctor dependence in the patient. (5.3)

Characteristics of 'Unbridled' Capitation

'Unbridled' capitation has a number of disadvantages. There is no direct means of using the system to pursue public policy in health care. The consumers standards may be met, but professional standards of health care may be ignored. The system might encourage some practitioners to curtail consultation time by issuing prescriptions, certificates or referral to hospital for further investigation, all of which may be welcomed by patients but could be wasteful of time, resources and money. Worse still, such behaviour might positively harm the health of patients (5.4, 5.5)

Characteristics of a Mixed System of Fee per Item and Limited Capitation

Since the incidence of minor episodic illness forms a relatively constant part of practice morbidity, a 'Limited' capitation system could be appropriately applied selectively to that part of the service which deals with these acute episodes of illness. This would remove the incentive to medicalise and treat trivial illness, and would restore the incentive to encourage self care and prevention. This would provide some guideline as to the percentage of net income to which limited capitation might contribute. (5.6)

A fee per item system of payment would apply to all other services and activities, which would include such clinical activities as the continuing care of patients suffering from chronic illnesses, scheduled surveillance of at Risk Groups; care of children and the elderly; approved preventive and screening measures; ante-natal and post-natal care; family planning counselling and domiciliary visiting. Clinical standards setting out the inclusion criteria and the content and frequency of visits

would be based on agreed management protocols. Provision would have to be made for exceptional cases. As a result the cost to the State could be more accurately estimated in advance and certain services could be extended to wider categories of eligibility. (5.6)

The College Proposals

We recommend the replacement of the global fee with a mixed system of payment for professional services and activities and an independent system of reimbursement for expenses including capital expenses.

We strongly recommend that expenses be paid only where incurred and that they may be estimated in real terms independent of fee income. This would allow both individual doctors and Government to spend and invest in general practice organisation without effecting net income either way. (5.7)

SPECIAL SERVICES: INCENTIVES TO IMPROVED QUALITY

Introduction

Chapter 6, contains a range of incentives to quality in most of the key areas of current practice. These could be regularly reviewed and updated to meet changing needs and priorities.

We propose that claims made under the system would be verified locally through the community physician whose role as an epidemiologist would be transformed, and in whom the process would gather valuable morbidity data. (6.1, 6.2, 6.3)

The Domiciliary and 'Out of Hours' Service

We make the following recommendations:

Pay realistic fees for domiciliary visits. (6.9)

Encourage delegation of revisiting. (6.9)

Allow adequate time for domiciliary care in the General Practitioner's work schedule. (6.9)

Pay consultants a realistic fee per item for joint domiciliary consultations at the General Practitioners' request. (6.9)

Reward doctors who provide an "Out of Hours" service. (6.9)

Provide patient education on the appropriate use of domiciliary care. (6.9)

Screening, Prevention and Health Education

We regard general practice as the ideal setting for these activities.

Everyone should be registered with or nominate a General Practitioner and every doctor should have an identifiable list of patients. (6.15).

Incentives should be provided to General Practitioners to provide services in areas of preventive care. (6.15)

(a) Immunisation.
(b) Antenatal and postnatal care.
(c) Child health surveillance.
(d) Family planning.
(e) Cervical cytology and breast examination.
(f) Hypertension and arterial disease.
(g) Screening of the elderly population.
(h) Psychological and psychiatric disorders.

These incentives could take the form of a fee per item for certain preventive services payable on notification of the service supplied, much like the present measles scheme. Bonuses might be added for those reaching or exceeding target percentage of the population at risk.

Incentives for the patient should also be considered and might mean that certain preventive services be made freely available to all the public, payable either by Government or V.H.I.

The activities of Community Physicians and General Practitioners should be complementary and not in competition. Wasteful duplication of effort should be avoided. (6.15)

Facilities for general practice outreach should be developed. (6.15)

The role of general practice in prevention and screening must be emphasised, additional resources sought and a campaign initiated to enhance public awareness of the General Practitioners preventive role. (6.15)

Much of the work of prevention, screening and health education should form part of the community surveillance role of the community nurse. (6.15)

Trainees and established General Practitioners will require education and training which takes account of the shift in emphasis implied in these developments. (6.15)

A system of programmed public education to promote uptake of these services and encourage more selfcare of minor illness. (6.15)

Working with the Primary Care Team

To make the primary care team work effectively we make the following recommendations:

Reform the system of payment to reward those General Practitioners who appropriately share the care of patients with other members of the primary care team. (6.21)

Reward General Practitioners who spend time in consultation with the team. (6.21)

Create practice registers. (6.21)

Define the responsibility of community care areas in terms of the population of the combined practice list of 40 to 60 General Practitioners who have centres of practice in a given area. (6.21)

Define the role of community physicians primarily as clinical epidemiologists. (6.21)

Urge public health nurses to retain their role as 'generalists'. (6.21)

Increase the number of Public Health Nurses to bring their ratio to General Practitioners closer to 1:1. Create General Practitioners – Public Health Nurse 'core teams' as the basic clinical unit of primary care. (6.21)

Regulate the piecemeal development of hospital outreach. (6.21)

Incorporate these strategies into a properly funded intergrated plan for the development of the services in the community, as a matter of urgency. (6.21)

Continuing Care

The College proposes that the continuing care of the commoner long term illnesses should also qualify for a special fee per item of service. The standards of care could be agreed in advance. Claims would be verified by the community physician on receipt of completed continuing care cards. The fee should be sufficient to encourage all General Practitioners to participate effectively. Patients should be encouraged by removing the differential for hospital card holders between visiting the clinic and visiting the General Practitioner. Patients with chronic illnesses should be treated in general practice either entirely or through formal combined care arrangements with hospital clinics.

This requires recall systems. Every patient fulfilling agreed entry criteria should be entered in a chronic illness register. Committees should be established to devise agreed entry criteria. (6.22, 6.23)

Everyone should be registered with or nominate a General Practitioner. (6.24)

Practice Organisation should be improved with facilities for recall and identification of at risk groups. (6.24)

Every patient fulfilling agreed entry criteria should be entered in a chronic illness register. (6.24)

Committees with Consultants and General Practitioners should be established to devise agreed entry criteria, protocols and combined care cards. (6.24)

There should be financial incentives for all those involved in combined care schemes. (6.24)

Other Opportunities for Combined Care with Consultants

We make the following recommendations:

Establish joint General Practitioner/Consultant Committees to draw up guidelines for the pre-referral investigation of specific conditions and devise protocols accordingly. (6.28)

Enable General Practitioners to investigate patients more fully by providing them with ready access to diagnostic hospital facilities. (6.28)

Provide them with reliable testing, transporting and reporting facilities in their own practices, and the adequate time and staff to use them. (6.28)

Pay General Practitioners a special fee for each completed pre-referral protocol. (6.28)

Devise similar agreed protocols and payments for the care of patients discharged early from hospital. (6.28)

Fund these special fees ultimately from the projected savings to be made in hospital costs. Do not however, expect them to achieve the full savings in the short term. (6.28)

The disincentive caused by the charge for diagnostic tests requested by the General Practitioner should be removed. (6.28)

Time for Teaching and Training

There is only a small percentage of General Practitioners involved in Teaching and Training. Little or no payment is available for these activities, and usually the time involved in teaching is taken out of the doctor's leisure time rather than being a part of the working day. Only 28 General Practitioners (1.6%) have a vocational trainee at any one time. The equivalent figure for the U.K. in 1981 was 7%. In addition, undergraduate student attachment is inadequate in most medical schools in Ireland.

General Practitioners are rarely involved in the teaching and training of other members of the primary care teams such as nurses and social workers.

To alter this situation we recommend the following:

Increase the number of vocational trainees by increasing the size and number of schemes. (6.32)

Provide a financial incentive to General Practitioners to become involved in teaching and training activities. (6.32)

Encourage partnership and group practices where practical. (6.32)

Reimburse 'start-up' costs. (6.32)

Invite teachers from other disciplines to become involved in training General Practitioners. (6.32)

Inservice Training, Continuing Education and Perpetual Performance Review

At present the established General Practitioner has no contractual obligation to undertake continuing medical education (CME). In addition there are powerful financial disincentives to doing so built into the current pay structure of general practice. The General Practitioner who actively pursues continuing medical education suffers loss of income, loss of leisure time and non-reimbursable expenses. The more time spent on CME the harsher these penalties become.

We recommend the following:

Provide adequate and appropriate CME, accessible to every General Practitioner. (6.42)

Establish broad educational goals. (6.42)

Establish suitable methods of active learning in every locality by extending rapidly the national network of General Practitioner tutors. (6.42)

Grant I.C.G.P. approval only to the CME activities which conform to specified educational standards. (6.42)

Channel funds, where possible, only to approved CME. (6.42)

Provide national courses on education methods and curriculum planning. (6.42)

Organise national and regional training courses in specific clinical skills. (6.42)

Confine special payment for some services to those holding certificates of satisfactory completion of relevant specific training courses. (6.42)

Include multidisciplinary conferences, and other approved review groups in the wider definition of CME/Performance review. (6.42)

Recognise as forms of CME approved distance learning. (6.42)

Regard each 'item' of CME as a "special service" qualifying for payment up to an agreed ceiling. (6.42)

Base the amount of such payments on the earnings lost during the time devoted to CME. (6.42)

Reimburse necessary locum expenses, and pay travel and subsistence allowances for attendance at regional and national meetings and courses. (6.42)

Government should support these measures for every doctor in full time general practice irrespective of GMS list size because of their importance to the cost of the hospital sector. (6.42)

PRACTICE ORGANISATION

Although good practice organisation does not inevitably lead to good medical practice it does make it more likely.

In Ireland there are almost no grants, loans or special subsidies available towards practice expenses. The percentage of the global fee devoted to practice expenses is entirely at the doctor's discretion and varies widely. Expenses account for more than 50% of the average British General Practitioner's gross practice income and State spending in real terms on the infrastrucuture of general practice in Britain is approximately three and a half times the Irish level.

Capital spending in general practice is at a very low level. In contrast there is a massive State investment in institutional care. Only practice premises qualifies for State subsistence in the form of a once off grant. In recent years these accounted for 0.0013% of the health budget.

We recommend the following:

Estimate in real terms the cost of providing adequate practice organisation, which should be paid independently of the fee, and not as a fixed or notional percentage of it. (7.32)

Establish a national agency which should be given the responsibility for surveying the capital and current spending requirements of general practice in line with overall health policy. (7.32)

Payment of all expenses should where possible, be by direct reimbursement of actual expenses incurred. This could be according to pre-agreed schedules or prior approval. (7.32)

The amount of expenses to be indirectly reimbursed should be re-negotiated. (7.32)

Extend State responsibility in regard to practice expenses beyond the GMS to include all patients registered with a practice. (7.32)

Structure systems of direct reimbursement to encourage the doctor to make a greater investment in the practice. (7.32)

Encourage employment of ancillary staff. (7.32)

Establish practice registers of all patients holding medical cards and hospital cards and all patients contributing to VHI. (7.32)

Devise a uniform national record for General Practitioner use and make it freely available. (7.32)

Require doctors wishing to claim special service payments for screening prevention, and the care of the chronically ill to maintain "At Risk" and "Disease Registers". (7.32)

Initiate pilot schemes in the use of practice computers. (7.32)

Encourage partnership of 2–5 General Practitioners in cities and larger towns. (7.32)

Make special provision, including the payment of special allowances for doctors working in areas where single-handed practice is the only option and the opportunities for cross cover are limited. (7.32)

Special consideration should be given to the specific problem of practice in certain rural areas. (7.32)

REFORM OF PRESCRIBING

Generic substitution has been proposed as a cost-saving method. The Irish College of General Practitioners would have to be assured regarding a number of quality issues relating to such substitutions before any such proposal could even be considered.

Limited lists have been operated both in hospitals and in general practice without hardship to either doctors or patients. In order to compile a limited list appropriate to general practice there would have to be the fullest consultation with this College. The operation of the list would have to be closely monitored and would have to incorporate a flexible system for making appropriate additions and deletions. There would also need to be flexibility in permitting exceptions in special circumstances. It must also be remembered that a limited list would not prevent the General Practitioner from prescribing items not on the list; it would however mean that the cost of such items would have to be borne by the patient. There seems no reason

why any limited list introduced should not apply to all categories of eligibility, and the College would oppose different 'lists' for those attending outpatient departments.

That is not to say that prescribing is not a quality issue. It certainly is, but we have come to the conclusion that the real reforms of prescribing must address the wide variation between individual prescriptions and their duration, and the problems of polypharmacy. These questions can only be answered by peer review and by General Practitioners as part of their work. Those who undertake such review should be paid for doing so.

A significant improvement in prescribing quality and cost could result not from reform of prescribing per se but from a change in the system of payment for consultations for minor illness.

We recommend the following strategies:

Provide vocational training for all those entering general practice. (8.10)

Promote an attitude of life-long learning amongst established General Practitioners. (8.10)

Provide effective continuing education particularly that which includes peer review of prescribing. (8.10)

Encourage consultations which include counselling, patient education, and general advice. (8.10)

Conduct public health education programmes. (8.10)

Provide a regular flow of unbiased drug information to prescribers, including reminders as to cost. (8.10)

Provide more specific feedback to prescribers designed to assist them in pin pointing personal prescribing idiosyncrasies. (8.10)

MANPOWER AND TRAINING

Neither the total number of General Practitioners or the rate at which numbers are changing are accurately known.

Serious over-doctoring particularly in some urban areas will undermine the service. The date is fast approaching when some modification of the traditional freedom to 'put up a plate' will be required. There must be an equitable system for selecting candidates for general practice.

No one entering practice should do so untrained. There are at present 28 recognised vocational training posts per annum. The number entering practice each year is in excess of 100 and the majority of those entering are forced to rely on what has been called self structured training.

We recommend the following strategies:

Manpower

Review the manpower requirements of Irish general practice. (9.6)

Frame a coherent manpower plan (9.6)

Ensure that all disciplines share the responsibility of providing a reasonable career structure for those already in training. (9.6)

Review methods of entry to the GMS. (9.6)

Training

Establish Chairs in general practice in all medical schools with full clinical departments. (9.12)

Expand Vocational Training rapidly to 75 places per annum. (9.12)

Invest in trainer's courses and training practices. (9.12)

Provide incentives to established General Practitioners to become involved in the training process. (9.12)

Make realistic formal commitment of hospital NCHD posts to general practice training. (9.12)

Ensure flexibility in structures of training. (9.12)

2

INTRODUCTION

Origin of the Document

2.1 At a meeting in Killarney in October 1985 a Working Group was established by the Council of the College to draft a policy document on this subject. The group reported to Council in September, 1986. Council adopted the report and published it as a discussion document in October, 1986. The discussion document was widely circulated and discussed, including a major debate at the College A.G.M. in Galway in May, 1987. The greater part of the discussion document was adopted as policy at the A.G.M. with the exception of certain sections which were referred back for re-drafting. In June 1987, a re-drafting group was appointed by Council. The re-drafting group met on a number of occasions and formulated a re-draft of the relevant sections which are incorporated in this document.

Previous Policy Statements

2.2 The College has already produced a number of policy documents on the organisation of health care:

In response to the G.M.S Working Party Report.
On practice expenses.
In response to the Psychiatric Services Report.
On the Modified Fee Proposals.
In response to the Tussing Report.
On "Public Health Nursing Services in Ireland".
On Care of the Elderly.

On "Health–The Wider Dimensions".
Submission to the "Commission on Health Funding".

2.3 Some of these have been considered by our Council; others have been widely discussed in Faculties. This document is a further step in the continuous evolution of a College policy.

Definition

2.4 The questions to be considered are deceptively simple:

(a) How can general practice be organised in the future so that while remaining cost effective, it delivers an enhanced quality of service to patients ?

(b) What should be its role in the overall context of the health services ?

2.5 What is meant by the 'organisation of general practice'?
We intend it to include all those parts of the system of medical care which relate to General Practitioners. On an individual basis for each General Practitioner and practice,it includes not just the setting, equipment, and staff but the timing, range, extent and quality of the services to be offered. It therefore involves the competence and professional values of those offering them. Collectively, for the discipline as a whole, it also includes the numbers and distribution of General Practitioners, the manner in which they enter practice and the training and education they receive.

Complementary Role of the College and the Irish Medical Organisation

2.6 The College is the statutorily recognised academic organisation for general practice in Ireland. Its objects are to encourage, foster and maintain the highest possible standards of practice. It is ultimately concerned therefore with the welfare of patients and the quality of the service they receive.

2.7 The relative roles of the College and the Irish Medical Organisation (I.M.O.) should be clarified. The role of the I.M.O. is to negotiate matters of pay and conditions on behalf of General Practitioners, and its primary purpose is to defend the interests of its members. For example, the College recognises the importance of public sector entitlements to General Practitioners but as a matter to be pursued by the I.M.O. The College on the other hand is concerned with standards of practice and the quality of service which General Practitioners can deliver.

2.8 It is entirely appropriate therefore that the College should examine the present state of general practice in Ireland, identify the priorities for reform and suggest strategies for change.

3

GENERAL PRINCIPLES

Equity and Uniformity

3.1 In our present system we endeavour to treat private and G.M.S. patients without distinction. This uniformity of standards should be maintained. This might mean that the system of payment, be it capitation, fee per item or a mixture of the two, for both G.M.S. and private patients should be broadly similar. However, nothing in this document should be taken as advocating the abolition of private practice.

3.2 We believe patients should also enjoy uniform standards in hospital care both in terms of the quality of medical care and in waiting times. Generous minimum standards of amenity in all hospitals should also prevail.

3.3 We support the concept of equity in the amount and distribution of resources. We believe that Category 1* eligibility should be legally defined, that standards of eligibility be indexed on a national earnings index to remove their adjustment from the political arena, and that Category 11* eligibility should

be based on family income and size rather than on the individual earnings of the head of the household.

* see appendix 1

Patient Choice

3.4 Irish patients have (and exercise) choice of General Practitioner. This vital element of choice has been increasingly disappearing from the hospital sector and there is every indication that this trend will continue. The use of catchment areas and sectorisation as proposed in the Psychiatric Services Report "Planning for the Future",[1] is evidence of such a trend. We regret this and believe it should be reversed.

Determinants of Quality

3.5 Obviously, such things as the standard of premises, equipment and the presence of ancillary staff are important. However the range and the extent of the services, and the times when they are available, are central to quality. They in turn depend on the competence, motiviation and professional values of each individual doctor.

Sources of Motivation: Attitudes and Professional Ethics

3.6 The emphasis in this document on financial incentives should not be taken as indicating that the College believes these to be the only or even the most important sources of motivation for doctors.

3.7 Abel Smith, in the course of a discussion of methods of payment of General Practitioners,[2] examined the potential for abuse, and the abuses which had been found to occur under a variety of payment systems. He noted that, while fee per item methods of payment offer a financial incentive to the doctor to offer more services than are needed by the patient, that the extent of this abuse varies considerably from country to country. In particular, he noted that abuses are comparatively rare in Sweden, more frequent in Germany and Switzerland, and felt to be most common in the United States. Similarly under capitation services, the incentive is for the doctor to over refer and to discourage calls from demanding patients. This appears to be uncommon in Holland and Britain, and more common in Austria. In the case of salaried services, there is a tendancy to adopt a low workload and to provide few home visits, but again the standard of service appeared to vary widely from country to country, being relatively high in Israel and the Soviet Union, but much less so in the Middle East and Latin America.

3.8 Abel Smith[2] concluded that "every system of payment can have undesirable effects on the use of resources and on the quality and character of care", and that "everything depends on the standard of medical ethics and on the profession's definition of good medical care". He also noted that if doctors are paid less than they think they deserve, they are more likely to respond to financial incentives to get more. He remarked that "the ideal remuneration

system which will encourage both quality and economy, which will secure an even distribution of services, promote effective preventive action as well as effective curative action, stimulate concern for patients' feelings as well as for their bodies, and establish medical priorities on the basis of need alone does not exist. . . .Under any system of payment it is the ethics and social commitment of the doctor which matter most of all." In this context it is interesting to note that the style of practice, the consultation and referral rates, and the attitudes of General Practitioners in Ireland and in the U.K., are remarkably similar, despite major differences in the financial structure of primary care. These marked similarities must be due in large part to the shared systems of training, attitudes, and the movement of large numbers of doctors between the two countries. A similar situation exists with respect to Germany, Switzerland and Austria, where attitudes and practices are similar, despite differences in the system of remuneration.

Sources of Motivation: Financial Incentives

3.9 As general practice in Ireland is now organised there is little or no financial incentive to quality practice. Indeed there are disincentives, because the doctor who invests in his premises, staff, equipment, records and organisation, and even in his own training and continuing education, usually earns less net income as a result.

3.10 As a general principle we recommend that incentives rather than penalties should operate throughout the system. It should discriminate in favour of those doctors who invest in their own skills, in improvements to their practices, and in the range of services offered. Such incentives should also become an instrument of policy to be used as necessary in those areas of practice considered by Government and the I.C.G.P. in consultation, to be in need of development. We advocate the principle of a performance sensitive contract, that is a contract in which improved quality of service is recognised and rewarded appropriately, and we believe the framework for such a contract is contained in our proposals.

Patient Incentives and Eligibility

3.11 We recommend that greater attention be paid to patient incentives. For example, it must be ensured that the position which pertained until recently whereby attendance at hospital was cheaper for most patients than a visit to their General Practitioner must not be allowed to recur.

The Extent of Government Interest in General Practice

3.12 Health authorities in Ireland have in the past tended to confine their interest in general practice to the G.M.S. sector. The G.M.S. Working Party Report[3] however, recognised and justified their wider interest:

"2.2. Furthermore, the behaviour and performance of General Practitioners towards their practice population as a whole is of direct interest to the public authorities in their concern to promote the health status of the population. It is of concern also because of the costs which fall to be met by the Exchequer

as a result of treatment decisions by doctors in respect of their private patients, particularly the cost of prescribed drugs (through the drugs refund and long term illnesses schemes) and referral to hospital (with free hospital treatment, both inpatient and outpatient, available to the entire population)".

The College welcomed this statement. In our view the G.M.S. cannot be considered in isolation. It is not only undesirable in social terms to differentiate it from private practice, but also impratical.

3.13 Equally general practice as a whole cannot be considered in isolation from the hospital services, particularly in any consideration of the cost effectiveness of health spending.

Evaluation of Change

3.14 It is essential that there is evaluation of the outcome of any proposed changes. General Practice can be assessed from two main viewpoints: quality of care, and cost effectiveness. In the past financial considerations have dominated discussion. This difficulty should be overcome by first introducing change in pilot schemes, which can be monitored and depending on the outcome either expanded or terminated. The financial implications of change should be evaluated in the wider context of the overall health budget.

The evaluation of change could be shared by the standard setting professional body, the paymasters, and the patients. The College thus advocates that participation in the process of assessment be extended to those who receive the service, as well as those who provide it and those who administer it.

4

TRANSFER OF CARE AND RESOURCES FROM THE HOSPITAL SECTOR

Historical Background

4.1 The application of science and technology to medical practice has brought about a gradual but fundamental shift in emphasis away from the original principles of treating whole persons (the Holistic Approach) to the less personal concern to reduce all problems to their component parts (Reductionism). This movement favours the use of ever more sophisticated technology and thus an increasing reliance on the institutional management of all medical problems. This, in turn, is reinforced by the public perception of hospitals and those who work in them, as the source of the technology without which their medical problems cannot be solved.

These developments have had the following side effects: Explosive cost inflation; centralised secondary care in larger bureaucratic hospitals; downgraded cottage and community hospitals; underused General Practitioner

skills and a decrease in confidence of the General Practitioner, patients and community colleagues in the General Practitioner's ability to deal with significant problems.

The lack of economic rationality and the explosive inflation of health costs referred to in the recent document entitled "Irish Medical Care Resources: An Economic Analysis" by A. Dale Tussing are largely attributable to the acute general hospital sector and its rapid expansion in the last ten years. In spite of public pronouncements to the contrary, community services have been relatively starved of funds.

Present Position: Decisions on Funding

4.2 Professor Tussing[1] makes the following startling observations on central decision making on hospital funding:

". . . the Department of Health makes its budget decisions affecting hospitals on an ad hoc basis in ways which are to the analyst obscure" and . . . "it is difficult to evaluate the present technique precisely because its incentive and allocational implications are not obvious without further research".

Present Position: Evidence of Growth

4.3 Tables 1. and 2. confirm the growth in recent years of hospital medical and non-medical manpower as the source of cost inflation. There was no equivalent growth in General Practitioner numbers in the G.M.S. during the same period.

Table 3. shows that increased expenditure over the years has been overwhelmingly devoted to the hospital sector with no evidence of any diversion of funds towards the community. It is sometimes suggested that investment in general practice should be undertaken by the doctors themselves. This is presumably to come from the 'expense element' of their fees. Table 3. shows why that suggestion is entirely unrealistic. Table 4. shows that capital investment is entirely in the hospital system.

Table 5. shows how it is much more expensive to the State for patients to attend hospital and, in particular, it highlights the enormous cost of inpatient care.

Table 1. The growth of hospital medical manpower between 1975 and 1984[2,3,4]

	Consultants	N.C.H.Ds	GPs in GMS
1975	839	1210	1270
1984/5	1150	1825	1418
% Increase	37%	51%	11%

Table 2. The growth in number of administrative and other staff in the health services between 1974 and 1981 (the period of most rapid expansion).[5]

	1974	1981	% Increase
Total staff of health Boards and Voluntary Hospitals	39,792	58,030	46%
Clerical and Administrative	3,428	5,891	72%
Paramedical Staff			91%
Medical and Dental			67%
G.P.s in G.M.S.	1,144	1,376	20%

Table 3. The growth in expenditure per year on the Acute General Hospital Programme and the Community Health Services Programme over the six years between 1978 and 1984.[6, 7]

	1978	1984	Increase in Annual Expenditure 1978–1984
	£	£	£
General Hospitals	195m	593m	398m
Community Health	53m	147m	94m
G.P. fees and drug costs	40m	96m	56m
G.P. Fees only	13m	29m	16m
'Expenses Element' (30% of fees)	3.9m	8.7m	4.8m

Table 4. Comparative Growth of Government Capital Expenditure on General Hospitals and General Practice 1977–1984.[6, 7]

	1977	1984	Increase in Expenditure/yr
	£	£	£
General Hospitals	9.46m	36.62m	27.16m
GP premises and Equipment	Nil	0.02m	0.02m

Table 5. Cost per patient treatment in General Medical Service and the General Hospital Programme in 1982.

		£
Average Total Cost of a G.M.S. visit (including medicines)	=	10.76
Average Total Cost of an OPD attendance (rarely includes medicines)	=	25.00
Average Total Cost of a hospital in patient admission	=	800.00

Note: These calculations assume that the ratio of cost of admissions to cost of OPD attendances is 32 to 1.[8]

Other evidence of expansion is quoted in the G.M.S. Working Party Report[4]:

There was a 33% increase in the number of inpatients treated in Acute General Hospitals in the period 1973–81;

Outpatient attendances at the Mater Hospital increased by 44% between 1977 and 1981 and at St. Vincent's Hospital by 28% between 1976 and 1981. No information is available on the percentage increase in new attendances.

Priorities for Reform

4.4 We recommend that a reversal of these trends must be the priority in health care planning. There should be a sustained effort to transfer care from the hospitals to the community by promoting the following changes:

(a) Rapid expansion of preventive care in general practice, balanced by a reduction in the volume of consultations for minor episodes of illness.

(b) More diagnostic investigation in general practice.

(c) Wider range of treatment available in general practice.

(d) Fewer referrals to outpatient clinics.

(e) Much earlier discharge from outpatient clinics.

(f) Joint G.P. / Consultant committees to agree criteria for the care of common chronic illnesses.

(g) Consideration of specialist 'consultation' with the General Practitioner in the domiciliary and surgery setting.

(h) Fewer and shorter admissions.

(i) More appropriate use of the Accident and Emergency departments of the hospitals.

(j) More low cost beds for geriatric care.

(k) A re-education of patient expectation and demand backed up by appropriate incentives in favour of primary care.

Strategies for Change

4.5 To achieve these changes we recommend the following strategies:

(a) Make general practice the setting of choice for prevention and screening services. Provide incentives for General Practitioners to develop such services. Encourage patients through local and national media campaigns to expect such services to be provided by their own General Practitioners.

Scale down existing clinic-based national programmes accordingly.

(b) Create incentives for General Practitioners to retain clinical responsibility rather than refer, without prejudicing quality of patient care.

(c) Provide incentives for the longer consultations required to manage certain conditions without referral.

(d) Provide incentives for those who acquire and use special skills, such as cryotherapy or minor surgery, in general practice.

(e) Create incentives for all patients to attend their General Practitioner rather than the outpatient / Accident and Emergency department of their local hospital.

(f) Enable and encourage referral between General Practitioners.

(g) Remove the barriers which prevent direct access by General Practitioners to services such as X-Ray, laboratory, day care, physiotherapy, psychology services, on behalf of their patients.

(h) Invest in General Practice record systems.

(i) Encourage everyone to nominate or register with a General Practitioner.

(j) Create incentives to investment in GP premises, staff and equipment.

(k) Invest in the Primary Care Team.

(l) Discourage follow up visits in accident and emergency departments and outpatient departments.

(m) Enable earlier discharge from hospital by properly assessing domestic circumstances in advance and providing adequate back-up afterwards.

(n) Establish combined care committees of General Practitioners and Consultants in all acute general hospitals to agree clinical management protocols for common conditions where transfer of care is appropriate.

(o) Appoint more Consultants with smaller Non-Consultant Hospital Doctor (NCHD) teams.

(p) Plan a gradual reduction in all hospital staffing levels in line with their reduced workload, and divert funds into community investment.

(q) Create incentives for Consultants to 'consult' outside the hospital setting at the request of the General Practitioner. Improve regular personal contacts between Consultants and General Practitioners.

(r) Develop proper geriatric care services with acute short stay, intermediate and long stay facilities. Provide adequate community contact and backup. Maintain close liaison between the General Practitioner and the Director of Geriatrics. Site day care centres in the community.

(s) Encourage a positive public attitude to the home care of terminal illness.

(t) Invest in General Practitioner training and retraining, and expand and reward continuing education and performance review.

(u) Re-educate the public, thereby revising patient attitudes to, and demands for the most expensive hospital care. Stimulate critical public debate of health spending issues. Question not just medical value but cost effectiveness.

(v) Do not set up special primary care clinics to correct deficiencies in existing areas unless it can be clearly shown that general practice, with appropriate assistance, is incapable of correcting them.

Conclusions

4.6 Expensive chaos will continue as long as there is no systematic approach to the tranfer of care in the administration of hospitals and in the policies of Government. The much publicised closing of wards and withdrawal of services by hospitals can only be regarded as unnecessary tactics in a political battle for funds, in which the only casualties are the sick and the disabled.

4.7 We recommend that there must be a comprehensive medium term plan, and an end to year-to-year financial uncertainty. That plan must include all the hospital and community services. The organisation of the latter service must be reformed to include the General Practitioner.

5

THE BASIC SERVICE FOR EPISODIC ILLNESS

Introduction

5.1 As a system of care General Practice can be divided into three parts:

The basic service for Episodic Illness.
Special Services and Activities.
Practice Organisation.

This chapter examines systems of payment and puts forward proposals which are further developed in subsequent chapters.

***Systems of Payment*:**

5.2 Under the present system, Irish General Practitioners receive a global fee per item of service either from patients directly or from the Government on their behalf. This fee is intended to include everything and is unrelated to the standard of service offered.

(i) ***Characteristics of the present fee per item system***

5.3 To be available and accessible to patients when they need help, and for whatever problems they decide to bring, is a central part of good general

practice and is an advantage of the present system. However, it is a fault in the present Irish fee per item of service system that the General Practitioner's income depends solely on the number of face-to-face consultations which can be fitted into each day. It may lead to medicalisation of minor illness and induce unhealthy doctor dependance in the patient. Time spent on non-clinical activities such as teaching, training, and consulting with nursing and other medical colleagues is not remunerated. The present system also eats into personal and family time for the doctor. A recent review (Maynard, Marinker and Pereira Gray)[1] commented on fee per item of service:

". . . there may be a conflict between quantity and quality. Payment by item of service places a cash value on almost every clinical decision. The whole thrust of thinking in modern general practice is towards economy of medical intervention: the health of the patient is best enhanced by an economy of investigation and medication and a restraint from the medicalisation of social and personal problems".

Practice activity analysis of antibiotic prescribing, 80% of which is not repeated within six months ('one-off'), has shown that once a patient consults with a problem the likelihood that an individual doctor will prescribe for that problem is fairly constant. Thus the level of prescribing is determined above all by the patient's initial decision to consult. Unnecessary consultations may lead to unnecessary prescriptions.

(ii) *Characteristics of 'Unbridled' Capitation*

5.4 In terms of quality there are strong arguments for some change in the fee per item system, at least as the method of calculating basic professional income. The alternative sometimes proposed (Mr. Barry Desmond T.D,[2] Irish Medical Times July 1986) is a capitation system whereby the level of the General Practitioner's income is determined by the number of patients the doctor can attract to his/her list. This may have the advantage of ensuring that the doctor is consumer orientated. However, if some form of capitation were to be considered, careful attention would have to be paid to the age structure and morbidity of each practice population. This might be determined from their known visiting patterns over a number of previous years.

5.5 However, if relied upon exclusively, systems of capitation also have disadvantages. Experience of these in the U.K. is well summarised by Maynard et al[1]:

"There is no direct means of using the system to pursue public policy in health care. The consumers' standards may be met, but professional standards of health care may be ignored. The system might encourage some practitioners to curtail consultation time by issuing prescriptions, certificates, or referral to hospital for further investigation, all of which may be welcomed by patients but could be wasteful of time, resources and money. Worse still, such behaviour might positively harm the health of patients.

In fact this (unbridled capitation) system was abandoned in the mid–1960's, when the reforms in the "General Practitioners' Charter" enabled Government to use new monies in the form of allowances and reimbursements to

pursue public policy for better premises and the employment of practice staff. The return to a pure capitation system now seems a retrograde step."

(iii) *Characteristics of a Mixed System of Fee per Item and Limited Capitation*

5.6 The *incidence* of minor episodic illness forms a relatively constant part of practice morbidity.

However the rate of *consultation* for minor epidosic illness varies widely depending on the attitudes of both doctors and patients. A capitation system could be appropriately applied selectively to that part of the service which deals with minor self-limiting episodes of illness. This would remove the incentive to medicalise and treat trivial illness. It would restore the incentive to encourage self care and prevention.

A fee per item system of payment would apply to all other services and activities, which would include such clinical activities as the continuing care of patients suffering from chronic illnesses; scheduled surveillance of at risk groups; care of children and the elderly; approved preventive and screening measures; antenatal and postnatal care; family planning counselling; and domiciliary visiting. Clinical standards setting out the inclusion criteria and the content and frequency of visits would be based on agreed management protocols. Provision would have to be made for exceptional cases. As a result the cost to the State could be more accurately estimated in advance and certain services could be extended to wider categories of eligibility.

General Practitioners must be motivated to expand and develop their services by being given some real incentive to do so. This may be in the form of improved job satisfaction, a more reasonable lifestyle or additional financial rewards.

Improved job satisfaction arises from the opportunity to use to the full, existing clinical and organisational knowledge and abilities, to acquire and apply new skills, to practice a higher standard of care, to expand a range of previously neglected services (such as preventive care, surveillance, screening and health education) and to communicate with medical colleagues, thereby reducing professional isolation.

The prospect of a better lifestyle will act as a strong incentive to most General Practitioners and more especially to their families. Reforms of the system which reduce the need for family involvement in the practice and make more effective use of the doctor's time are overdue. They should include standing arrangements which guarantee time for holidays, study leave, and sickness and retirement income.

The majority of General Practitioners committed to improving the services they offer are entitled to expect that they will be financially rewarded for doing so.

The College Proposals

5.7 We recommend the replacement of the global fee with a system of payment which would include both a professional fee (however calculated), and an independent system of reimbursement for expenses, including capital expenses.

We strongly recommend that expenses be paid only where incurred and that they be estimated in real terms independent of fee income. This would allow both individual doctors and Government to spend and invest in general practice organisation without effecting net income either way.

The separate arrangements necessary for the development of practice organisation are considered in detail in Chapter 6.

6

SPECIAL SERVICES: INCENTIVES TO IMPROVED QUALITY

Introduction

6.1 For those concerned with the quality of the service which the patient receives, namely the patients themselves, the profession as represented by the I.C.G.P., and the State as represented by the Department of Health, this is the critical chapter in the College proposals. It contains a range of incentives to quality in most of the key areas of current practice. It proposes rewards for a number of activities to which only disincentives now apply. These include clinical areas such as continuing care, prevention and screening and non-clinical areas such as teaching, training and continuing education. It is a flexible system which can be regularly reviewed and updated to encourage needed services and to meet changing priorities.

6.2 Payment for the special services listed above would be based on what the doctor does, and for whom, and not just on the frequency of consultation. Its cost can be predicted in advance in most cases and therefore budgeted and negotiated realistically.

6.3 Furthermore, claims made under the system can be verified locally, since most will be channelled through the community physician, whose role as an epidemiologist would be transformed by these proposals. In addition, the flow of morbidity data and clinical statistical information would greatly enchance the work of health economists and planners.

6.4 The suggestions made about the reform of community care, in our opinion, are the first realistic attempt to establish primary care teams in this country.

The Domiciliary and "Out of Hours" Service

(a) *Present Position*

6.5 A domicilary service and 24 hour cover are essential features of good general practice. They are a practical expression of the doctor's continuing commitment to the patient. Visiting the patient at home also provides important insights into the context of the patient's illness or disability. In the G.M.S. domiciliary fees, 'late' and 'night' rates are higher than surgery fees. The differential is presumably intended to reflect both their cost and value. However, the size of the differential is insufficient to meet the expenses in time and travel involved in domiciliary visiting (see Chapter 7) and for "Out of Hours" work compares poorly with rates paid to other health workers providing emergency services.

	Ireland (Total GMS Population 1986)[1]	U.K. (FRY) (Total Population)[2]
Ratio of Domicilary to Surgery Visits	1:4.6	1:8–15

6.6 In the G.M.S. the domiciliary visiting rate is relatively high when compared with rates from the U.K. Studies there have shown that some domiciliary visits are avoidable and that where rates are high the main cause is usually a high rate of revisiting.[3] However, the proportion of elderly patients, which is relatively high in the G.M.S. population,[1] must also be a factor.

6.7 Familiarity with the patient is an important determinant of quality in an "Out of Hours" service. The best service should be that provided by the patient's own doctor or one of a small number of partners known to the patient. Deputising services are an inevitable though less desirable substitute, yet fees are paid at the same rate. Quality is not rewarded.

(b) *Priorities for Change*

6.8 (i) Domiciliary care as a vital component of general practice should be encouraged and maintained. The cost effectiveness of revisiting and the extent to which it could be delegated or shared with the community nurse should be examined.

(ii) Domiciliary visits by Consultants at the General Practitioner's request should be encouraged. This works well in the U.K. especially in geriatrics and psychiatry.

(iii) Those who provide a quality "Out of Hours" service (as defined above) should be rewarded for doing so.

(iv) Special consideration should be given to remote rural and city centre areas.

(c) *Strategy for Change*

6.9 We make the following recommendations:

(i) Pay realistic fees for domiciliary visits.

(ii) Encourage delegation of revisiting.

(iii) Allow adequate time for domiciliary care in the G.P. work schedule.

(iv) Pay Consultants a realistic fee per item for joint domiciliary consultations at the General Practitioner's request.

(v) Reward doctors who provide a good "Out of Hours" service (personally or through small, named, stable rotas).

(vi) Provide patient education on the appropriate use of domiciliary care.

Screening, Prevention and Health Education

(a) *Introduction*

6.10 These activities are complementary but not the same. Screening implies actively seeking out a population of people and checking them for a particular condition. The Royal College of General Practitioners define prevention as 'anticipatory care' or care with an eye to the future. This is a useful definition and suits the context of general practice.

(b) *The Present Position*

6.11 Screening and prevention in general practice are done on a haphazard basis and there is little firm evidence of how often these activities are done and whether they are effective. A major problem is that only 40% of the population in the GMS[1] are formally registered with a General Practitioner.

Many practices are inadequately organised, resourced and staffed for good preventive care.

6.12 Remuneration for these activities is almost non-existent. Instead there is active discouragement of any activity which would increase the 'visiting rate' for the G.M.S. patients above the norm.

6.13 There is a gross lack of co-ordination,and some screening is being done outside the confines of general practice by either community care personnel or other bodies such as the Irish Heart Foundation or the Irish Cancer Society. Some of these bodies may advertise their services while General Practitioners may not. In addition, the present volume of consultations leaves less time for preventive and screening activities.

6.14 On a more positive note, General Practitioners have the advantage of seeing 70% of their patients in any one year, and 95% over a five year period.[4, 5] They are thus in an ideal position to carry out opportunistic screening. The success of the recent measles vaccination campaign has shown that General Practitioners can cooperate with others to carry through a successful preventive scheme.

(c) *Priorities for Reform and Strategies for Change*

6.15 We make the following recommendations:

(i) Everyone should be registered with or nominate a General Practitioner and every doctor should have an identifiable list of patients.

(ii) Incentives should be provided to General Practitioners to provide services in the following areas of preventive care:

a. Immunisation

b. Antenatal and postnatal care.

c. Child health surveillance.

d. Family Planning.

e. Cervical cytology and breast examination.

f. Hypertension and arterial disease.

g. Screening of the elderly population.

h. Psychological and psychiatric disorders.

These incentives could take the form of a fee per item for certain preventive services payable on notification of the service supplied, much like the present measles scheme. Bonuses might be added for those reaching or exceeding target percentages of the population at risk.

Incentives for the patient should also be considered and might mean

that certain preventive services be made freely available to all the public, payable either by Government or by the V.H.I.

(iii) The activities of community physicians and General Practitioners should be complementary and not in competition. Wasteful duplication of effort should be avoided.

(iv) General Practitioners and the community care and epidemiological services should co-operate closely.

This would provide health targets and lead to an integrated service as was shown by the measles campaign, and as has been proposed for cervical screening, (Johnson & Johnson 'Cerviscan').[6]

(v) Facilities for general practice outreach should be developed. These would include registers, mailing systems, recall systems and systems of notification. Target populations should be identified, contacted and where necessary followed up in co-operation with members of the community care team.

(vi) The role of General Practice in prevention and screening must be emphasised, additional resources sought and a campaign initiated to enhance public awareness of the General Practitioners preventive role.

(vii) Much of the work of prevention screening and health education should form part of the community surveillance role of the community nurse as envisaged in the recent discussion document by the Department of Health.[7]

(viii) Trainees and established General Practitioners will require education and training which takes account of the shift in emphasis implied in these developments.

(ix) A system of programmed public education should be established to promote uptake of these services and encourage more selfcare of minor illness.

Working with the Primary Care Team

(a) *The Present Position*

6.16 The development of effective primary care teams in Ireland has been blocked by two fundamental problems. The present fee per item system may discourage delegation by General Practitioners to other team members because this involves loss of income. More importantly,the community care area system is geographically based, whereas individual practices generally overlap. In effect, this means a mismatch between the practice population and the patient population of the public health nurse and other community health workers. As a result the average General Practitioner works with several public health nurses and the average public health nurse works with several General

Practitioners. This is administrative chaos and has led in our view to a widening communication gap between the General Practitioners and the public health nurses. As long as there is choice of doctor (which we regard as a fundamental patient right), general practice can never be defined in catchment areas. This suggests that if primary care teams are to become a reality, the population for which the community care team is responsible must be defined in some other way.

6.17 Community physicians assume health care responsibilty for defined populations; General Practitioners provide services for individuals. The roles are complementary and should not conflict. In practice the distinction is less clear cut. Some community physicians in addition to their role as epidemiologists, have become specialists in certain clinical areas such as child development assessment and the management of tuberculosis in the community. These services should be regarded in the same way as all other specialist services and provided only on referral from the family doctor. On the other hand some General Practitioners have begun to adopt a population approach to their practice lists. They should be encouraged and advised in these developments by their local community physician.

6.18 Recently, a number of hospital based specialist services have extended their activities into the community. Such developments are the central theme of the psychiatric services report "Planning for the Future".[8] Paediatric and geriatric day care facilities are further examples of this trend which in general is welcomed by the College. We do however have serious reservations. Little thought has apparently been given to the integration of these new services with existing community structures. Each development is seen in isolation. The planned facilities will function independently from 'nine-to-five' Monday to Friday and will use General Practitioners only to provide their 'out of hours' cover. They may even include 'walk-in' services competing directly with family doctors, seeing patients who could be more appropriately managed by their own General Practitioner. For patients they will have the added attractions of being free of charge, expensively built, equipped and staffed, and in some cases the only means of access to social workers, physiotherapists, psychologists, and other skilled personnel.

6.19 Much has been written recently about the role of the public health nurse. (Public Health Nursing in Ireland: Discussion Document, Department of Health). There are currently 1,176 public health nurses employed. The overall average public health nurse population ratio is 1:2928, and the ratio of public health nurses to General Practitioners is 1:1.57. The role of the public health nurse has been considered under three headings: surveillance, non-clinical, and clinical. There is a widespread impression that future development of the nurses' role will be in the first two areas at the expense of the third.

In the U.K. these functions are split between two professionals: the district nurse and the health visitor. In addition a smaller number of practice nurses are employed. Overall the ratio of nurses to General Practitioners in the U.K. is 1:0.90, and the nurse/population ratio is 1:1722.[9]

(b) *Priorities for Reform*

6.20 (i) The current method of payment whereby the General Practitioner is rewarded financially only for delivery of items of service personally should be changed so as to provide an incentive to delegation.

(ii) The establishment of effective primary care teams should be a central objective in the development of the community services.

(iii) General Practitioners and public health nurses should be encouraged to work closely together.

(iv) General Practitioners should be able to spend item without loss of income in regular consultation with the public health nurses and in conference with the wider community care team.

(v) In the light of a reorganised general practice service, a fundamental review of the community services should be conducted as a matter of urgency.

(c) *Strategies for Change*

6.21 We make the following recommendations:

(i) Reform the system of payment to reward those General Practitioners who apropriately share the care of patients with other members of the primary care team. List the activities which could be claimed for,even when delegated.

(ii) Reward General Practitioners who spend time in consultation with the team. Pay a special service fee per item for such consultations up to agreed limits.

(iii) Create practice registers as outlined in Chapter 7.

(iv) Define the responsibility of community care areas in terms of the population of the combined practice lists of 40 to 60 General Practitioners who have centres of practice in a given area.

(v) Define the role of community physicians primarily as clinical epidemiologists. Enable them to fulfil that role by greatly increasing their involvement in the prevention, screening and continuing care services of the practices which make up their areas. Enable some to opt for specialisation in their traditional clinical areas but transfer responsibility for immunisation, child development surveillance and other routine screening to general practice.

(vi) Urge public health nurses to retain their role as 'generalists' combining traditional clinical nursing duties with surveillance and non-clinical roles in health education and prevention. The role of the superintendent public

health nurse might develop in much the same way as that of the community physician so that her relationship to the public health nurses in her area would be that of consultant and colleague.

(vii) Increase the number of public health nurses to bring their ratio to General Practitioners closer to 1:1. Create General Practitioner–public health nurse 'core teams' as the basic clinical unit of primary care.

(viii) Regulate the piecemeal development of hospital outreach so that
- specialist community facilities would operate only on referral;
- their activities would be integrated with those of the primary care team;
- standing arrangements would be made for day to day communication;
- General Practitioners would have direct access to the other skilled professionals who make up the service;
- community based facilities would be administered from the community rather than from a number of central hospital administrations.

(ix) Incorporate these strategies into a properly funded integrated plan for the development of services in the community, as a matter of urgency.

Continuing Care

(a) *Introduction*

6.22 Continuing care has been described as 'the very stuff of general practice'[10] (J.Hasler JRCGP) and this is reflected in the increasing literature devoted to it.[11, 12] ('Continuing Care': Hasler & Schofield. OGPS and 'Primary Health Care': Scott. Springer Verlag). Every doctor should be able to name the patients in his practice suffering from chronic illnesses, such as hypertension, diabetes, asthma, epilepsy, and should be able to review them regularly and recall them if they fail to attend.

(b) *The Present Position.*

6.23 (i) Formal Responsibility.
About 60% of the population are not formally registered with a doctor. This is undesirable for continuing care. Informally a large proportion of the unregistered population do in fact identify with a particular doctor.

(ii) Hospital Outpatient Attenders.
Many patients who are regular attenders at outpatient clinics with chronic problems receive care from a succession of different Non Consultant Hospital staff and thus continuity is lost. Responsibility for these patients is also often split between general practice and hospital.

(iii) Continuing Care in Single Handed Practice.
The high proportion of single handed practices in Ireland (75% in the RCGP survey: Oliver et al)[13] should in theory mean better continuity of care.

(iv) Deficiencies in Recall Systems.
At present General Practitioners depend on patients returning voluntarily for follow-up visits. Facilities for recall or for identifying patients at risk, or with a particular problem that might need close follow-up, are generally very poor.

(v) Financial Barriers.
For many patients it is less expensive to seek continuing care at hospital outpatient clinics rather than to attend their General Practitioner. In 1982 the average cost to the State of an outpatient department visit was £25.00 [14]

(c) *Priorities for Change*

(i) Registration.
Every patient should either register with, or nominate a General Practitioner.

(ii) Chronic Illness.
Patients with chronic illnesses should be treated in general practice either entirely, or through formal combined care arrangements with hospital clinics.
The following are the commonest chronic diseases.[15]

1. Hypertension.
2. Chronic Rheumatism (OA & RA)
3. Chronic Psychiatric Problems.
4. Ischaemic Heart Disease.
5. Chronic Obstructive Airways Disease.
6. Obesity.
7. Congestive Cardiac Failure.
8. Anaemia.
9. Cancers under care.
10. Asthma.
11. Diabetes.
12. Varicose Veins.
13. Peptic Ulcers.
14. Strokes.
15. Thyroid Disorders.

16. Epilepsy.
17. Multiple Sclerosis.
18. Parkinsonism.

Note: These conditions would involve 33% of the patients on the average doctor's list not allowing for double counting.

(iii) Personal Lists.
If group practices are to become the norm in the future, we should aim for personal lists rather than group lists. These lead to better doctor/patient relationships, better patient compliance and better definition of where responsibility lies in relation to particular patients.

(iv) Recall System.
We should have some system whereby we can identify patients with chronic conditions who need regular review.

(d) ***Strategies for Change***

6.24 We make the following recommendations:

(i) Everyone should be registered with, or nominate a General Practitioner.

(ii) Practice Organisation should be improved with facilities for recall and identification of at risk groups e.g. age/sex registers, diseases index, at risk registers etc.

(iii) Every patient fulfilling agreed entry criteria should be entered in a chronic illness register. For example, a General Practitioner with a practice of 2,000 patients might expect to have approximately 25 diabetics. Some of these would need to be supervised in hospital diabetic clinics, some could be in combined hospital/General Practitioner care, and some could be supervised entirely by their General Practitioner. Under the College proposals their initial registration would be notified to the local community physician, to whom subsequent claims for visits would be returned.

(iv) Committees with Consultants and General Practitioners should be established to devise agreed entry criteria, protocols and combined care cards.

(v) There should be financial incentives for all those involved in combined care schemes. This would include the patient, the General Practitioner, the Consultant, the hospital management, and the paymaster (Government or the VHI). In addition, funds should be made available to build, equip, and staff the necessary organisation in general practice. Incentives must also be provided to those forming the General Practitioner/Consultant planning and review committees.

Other Opportunities for Combined Care with Hospitals

(a) ***The Present Position***

6.25 We have already referred to the transfer of care from expensive inpatient facilities out into the community. So far this has been implemented in a spirit of confrontation, with much publicised closing of wards and withdrawal of services by hospitals whose budgets have been arbitrarily cut. There must be a better way.

6.26 Much effort has been expended by hospital administration devising ways of providing the same standards and volume of services more cost effectively. There is a limit to the savings which can be made, unless some of the services now provided in hospital are offered in the community. We have already suggested the expansion of combined care of chronic illness. Other measures could also be introduced.

(b) ***Priorities for Reform***

6.27 (i) Patients should be discharged back to the care of their General Practitioner much sooner.

(ii) Consultants and General Practitioners should agree protocols for the combined care of the commoner conditions requiring investigation and follow up.

(c) ***Strategies for Change***

6.28 We make the following recommendations:

(i) Establish joint General Practitioner/Consultant committees to draw up guidelines for the pre-referral investigation of specific conditions and devise protocols accordingly.

(ii) Enable General Practitioners to investigate patients more fully by providing them with ready access to diagnostic hospital facilities.

(iii) Provide them with reliable testing,transporting and reporting facilities in their own practices, and adequate time and staff to use them.

(iv) Pay General Practitioners a special fee for each completed pre-referral protocol.

(v) Devise similar agreed protocols and payments for the care of patients discharged early from hospital.

(vi) Fund these special fees ultimately from the projected savings to be made in hospital costs. Do not, however, expect to achieve the full savings in the short term.

(vii) The disincentive caused by the charge for diagnostic tests requested by the General Practitioner should be removed.

Time for Teaching and Training

(a) *Present Position*

6.29 This document does not contain detailed proposals for the development of teaching and training in general practice. These have been set out in previous College publications[16] and are also the subject of a Departmental review[17] in response to the 1986 *E.E.C. directive on Vocational Training.[18] We do, however, make suggestions on the changes in the organisation of general practice necessary to meet the requirements of expansion in teaching and training.

*Note: The E.E.C. directive will require a mandatory minimum of two years vocational training for all entrants to State social security systems such as the G.M.S. from 1995.

6.30 There is only a small percentage of General Practitioners involved in Teaching and Training. Little or no payment is involved for these activities, and usually teaching time is taken out of the doctor's leisure time rather than being a part of the working day. Only 28 General Practitioners (1.6%) have a vocational trainee at any one time. The equivalent figure for the U.K. in 1981 was 7%.[19] In addition, undergraduate student attachment is inadequate in most medical schools in Ireland.

General Practitioners are rarely involved in the teaching and training of other members of the primary care team such as nurses and social workers.

(b) *Priorities for Change*

6.31 (i) Undergraduates should spend more time in the general practice setting.

(ii) Many more General Practitioners must be persuaded to become involved in teaching and training. Practices must be designed to take students and trainees.

(iii) Time spent on teaching and training should be an accepted part of the General Practitioner's working day.

(iv) General Practitioners should be more involved in the teaching and training of other members of the primary care team.

(c) *Strategies for Change*

6.32 We make the following recommendations:

(i) Increase the number of vocational trainees by increasing the size and number of schemes.

(ii) Provide a financial incentive for General Practitioners to become involved in teaching and training activities. This should be in the form of a basic allowance and / or special sessional payments per hour for one-to-one teaching. In addition, the arrangements suggested for continuing education (paragraph 6.42) should be extended in the case of teachers and trainers to enable them to participate in learning away from the practice, such as trainers workshops, trainers courses and hospital refresher courses.

(iii) Encourage partnership and group practices where practical since they are generally better able to cope with the disruption of patient care and the loss of professional time caused by teaching and training.

(iv) Reimburse 'start up' costs, such as the provision of separate consulting rooms, adequate library facilities and teaching aids, to those undertaking the training of students and trainees.

(v) Invite teachers from other disciplines to become involved in training General Practitioners and offer a General Practitioner input into their teaching programmes. Encourage multidisciplinary sessions.

In-service Training, Continuing Education and Perpetual Performance Review

(a) *Present Position*

6.33 At present the established General Practitioner has no contractual obligation to undertake continuing medical education (CME). In addition there are powerful financial disincentives to doing so built into the current pay structure of general practice. The General Practitioner who actively pursues continuing medical education suffers loss of income,loss of leisure time and non-reimbursable expenses. The more time spent on CME the harsher these penalties become.

6.34 It is gratifying that, notwithstanding these disincentives, there are many General Practitioners who take an active interest in CME. However, much of the traditional CME activity has been of little educational value. This is because its content is chosen at random with no clear objective; learning is entirely passive, requiring little more from the General Practitioner than attendance. The General Practitioner's knowledge, skills and attitudes are not elicited and no attempt is made to assess whether subsequent clinical behaviour has been altered. Some CME intended for General Practitioners is organised and delivered entirely by those working in other disciplines.

6.35 Since 1981, the Postgraduate Medical and Dental Board[20] has funded a developing network of General Practitioner tutors, based on proposals brought forward by the Irish Institute of General Practice. The proposals envisaged that 25–30 tutors would serve the needs of the country. So far, ten General Practitioners have been appointed as part-time tutors. Their function

is to establish peer review groups of General Practitioners in their areas, and to devise for them programmes of active learning.

Since 1986 the ICGP has taken over the supervision of these schemes. In December 1985, the Postgraduate Medical and Dental Board approved in principle the appointment of a national director of Continuing Medical Education to co-ordinate the future development of the schemes and this appointment has now been made by the College. These proposals received the following endorsement from the GMS Working Party Report:[21]

"We recommend that this mode of provision of continuing education be developed and expanded to the point where all doctors who are able and willing to participate have the opportunity to do so."

6.36 The establishment of Faculties of the ICGP has also led to a blossoming of small group activity in many parts of the country.

6.37 There is increasing international emphasis on continuing education in general practice, and particularly on quality assessment. It has been the subject of recent publications from the WHO Regional Office for Europe,[22] UEMO,[23] the New Leeuwenhorst Group[24] and the RCGP.[25]

(b) *Priorities for Change*

6.38 Throughout the course of their professional careers, General Practitioners should experience influences which would be designed to encourage and foster their interest and participation in CME. Continuing Medical Education should not be a mere academic exercise but should become the indispensible key to improving the range and quality of the services offered to patients. Improved services should in turn be rewarded financially.

CME should be designed with the following objectives for the participants:
- to identify and fill gaps in their knowledge;
- to enable them to refresh or acquire the skills and expertise required to provide specific services to the practice population;
- to allow their attitudes and values to be tested against those of colleagues providing the same service under similar conditions;
- and to enable their performance to be examined regularly in a critical, but constructive and non-judgemental, manner.

6.39 This implies that the ICGP, as the standard setting academic body, should be constantly defining and redefining the standards in Irish general practice. Based on those definitions it should set educational goals and priorities for change. It should organise and/or approve only those training and educational activities which advance these objectives.

6.40 Participation in CME however, should not be regarded as an end in itself. Its value lies in the implementation of the learning objectives in the doctors' practice.

6.41 Finally, CME should be regarded as part of the normal work of the General Practitioner. General Practitioners should neither have to take time out of their already limited leisure to pursue CME, nor be financially penalised for doing so.

(c) *Strategies for Change*

6.42 We make the following recommendations:

(i) Provide adequate and appropriate CME, accessible to every General Practitioner.

(ii) Establish broad educational goals.
This should be a College responsibility, in consultation with the statutory authorities. Most of these goals will be derived from the developments and reforms suggested throughout this document, and should be regularly reviewed. In addition to any national objectives, there should be a flexible component in the CME programme which would enable other educational needs to be catered for, on a local or individual basis.

(iii) Establish suitable methods of active learning in every locality by extending rapidly the national network of General Practitioner tutors.

(iv) Grant ICGP approval only to those CME activities which conform to specified educational standards.

(v) Channel funds,where possible, only to approved CME.

(vi) Provide national courses on education methods and curriculum planning for GP tutors and others organising small group CME at Faculty level.

(vii) Organise national and regional training courses in specific clinical skills, and issue certificates of satisfactory completion.

(viii) Confine special payment for some services to those holding certificiates of satisfactory completion of relevant specific training courses.

(ix) Include multidisciplinary conferences, regular primary care team meetings, General Practitioner/Consultant combined care committees and other approved review groups in the definition of CME/Performance Review.

(x) Recognise as forms of CME approved distance learning, approved practice audit, data gathering in 'sentinel' practices, and participation in practice activity analysis.

(xi) Regard each 'item' of CME as a 'special service' qualifying for payment up to an agreed ceiling.

Only approved activities would qualify and evidence of active participation would have to accompany all claims.

(xii) Base the amount of such payments on the earnings lost during the time devoted to CME.

(xiii) Reimburse necessary locum expenses, and pay travel and subsistence allowances for attendance at regional and national meetings and courses.

(xiv) Government should support these measures for every doctor in full time general practice irrespective of GMS list size because of their importance to the cost of the hospital sector. Special arrangements should be made for those in part-time practice.

The total cost of State support should be largely predictable in advance allowing accurate budgetary allocations to be made.

6.43 A system needs to be devised which would stimulate demand for CME, and raise the standard of service by gradually inducing change in the structure and staffing of practices. This process must begin with the provision of the correct type of CME for General Practitioners and the removal of the disincentives which are now inhibiting progress. We believe the College proposals offer just such an opportunity.

7

PRACTICE ORGANISATION

Introduction

7.1 Although good practice organisation does not inevitably lead to good medical practice, it does make it more likely. Certainly poor organisation inhibits good practice. Thus improving the standard of practice organisation is central to the aims of the College.

7.2 This chapter sets out the present state of practice organisation and expenses in Ireland, the reforms that are needed, and the incentives that might be applied to induce change.

7.3 British experience in this area is particularly relevant. In 1966 a new charter

for general practice[1] was introduced which provided substantial financial assistance for the improved organisation of general practice. Developments in British general practice since then provide evidence of the beneficial effects of such inducements.

Practice Premises

7.4 Irish General Practitioners practice from a variety of premises. An RCGP survey in 1982[2] showed that 24% had purpose built premises, 42% had adapted premises separate from their residence and 32% had their premises attached to or formed part of their private residence. The more recent General Practitioner Wives Association survey in 1986[3] showed that 56% had their premises separate from their residence, 29% worked from their residence, 8% worked from health centres, and a further 8% split their work equally between a health centre and either a residence or a separate premises.

7.5 In the U.K. a major effect of the 1966 Charter in the National Health Services has been the increased number and improved standards of practice premises, either privately owned by General Practitioner groups, or as health centres owned by the health authorities. There, the General Practice Finance Corporation, funded by the Government, provides loans at preferential rates for the purchase of practice premises and equipment. In addition, all spending on rent and rates is completely reimbursable. Although most British General Practitioners practice from privately owned premises, there has been an enormous increase in the number of health centres, and in 1983 24% of all National Health Service General Practitioners practised from health centres. In Northern Ireland the figure was 58%.[4]

Ancillary Staff

7.6 In Ireland, ancillary staff refers almost exclusively to secretarial/reception staff but can include a practice nurse or physiotherapist. The 1982 RCGP survey[2] showed that 36% of Irish GPs employed full-time clerical staff and 32% part time staff. The 1986 GPWA Survey[3] showed that 39% employ full time staff, 34% part-time staff, and 27% employ no secretarial staff. The spouses of most of this last group provide secretarial assistance. The same survey showed that 3% of General Practitioners employ a full-time practice nurse, and 6% part-time. Only one doctor, out of the total sample of 141, employed a part-time physiotherapist. Public health nurses are not based in General Practitioner practices and the RCGP survey[2] showed that only 24% of General Practitioners had a Public Health Nurse working in the same premises. In the light of these figures the implementation of the primary health care team concept is still at a rudimentary stage in Ireland.

7.7 Since the introduction of the 1966 General Practitioner Charter in the U.K.,[1] 70% of all staff salaries (up to a maximum of two employees per General Practitioner) is reimbursed from government funds. The balance of expenditure on staff is expected to be met through the expenses element in gross capitation and other fees. In 1982 there were approximately 30,000 General Practitioners in the NHS employing 45,000 secretaries / receptionists and 3,500 practice nurses[5]. This was in addition to attached staff employed by the local health authorities such as 10,000 health visitors, 21,500 district nurses and 3000 community midwives. Staff employed in primary care include social workers, home helps and physiotherapists.

Records and Registers

(a) *Patient Records*

7.8 Records should include clinical notes written by the General Practitioner at the time of consultation, copies of referral letters, specialist and hospital reports, laboratory and X-Ray reports, and other miscellaneous records including maternity co-operation cards, ECGs and 'problem list' sheets.

In Ireland there is at present no uniform or preferred format for individual patients' records in general practice. A4 folders and RCGP cards with envelopes are provided by the health boards for use as GMS patients' records. Other card systems are available commercially.

A small number of General Practitioners are developing computer based systems.

There is no formal method of transferring patients' records when they decide to change doctor. Informal arrangements can be made but, in practice, records often fail to be transferred.

The GMS Working Party Report[6] stated:

"General Practitioners cannot operate an effective record system without appropriate secretarial and administrative support. . . We recommend that future contracts should specifiy minimum standards of record systems to be maintained by all participating doctors."

No recommendations were made regarding the standardisation and formal transfer of records. However, reviews of the GMS have referred to both these issues, to no apparent effect.

7.9 In the U.K., a choice of patient record is supplied free in respect of all patients who are obliged to register with a General Practitioner and receive an NHS number. The medical record is transferred with all subsequent changes of doctor, so that there is continuity. Files are the property of the NHS, and General Practitioners are obliged to co-operate in their transfer. However, the administrative arrangements for this are made, free of charge, by a central agency. A Government funded pilot project on the use of practice computers should have considerable relevance to this country.

(b) *Registers*

7.10 In Ireland, private patients do not formally register with a General Practitioner, and an accurate patient register can be drawn up only for GMS patients. The difficulty of compiling a full and accurate patient register is a major drawback for Irish practice.

7.11 Registers are extremely useful, if not indispensible, for the care of the chronically ill, for screening and prevention programmes, for the anticipatory care and surveillance of those at risk, for most forms of practice audit and for practice research.

7.12 The age/sex register is widely used internationally. It enables the General Practitioner to know and list accurately and quickly any 'target' group within the practice, such as the elderly, children under five, or women of childbearing age. A recent survey in England in 1985,[7] showed that 52% of practices have an age/sex register. (Of these about 90% are either card index or loose-leaf, and 10% are computerised). No reliable figures are available for the number of Irish practices with age/sex registers.

Other registers include:

Disease Registers: (recording the names of patients with particular diseases).
At Risk Registers: (lists of patients who require special surveillance because of factors in their past history or social circumstances).
Repeat Prescriptions Register.
Cervical Smear Register.
Immunisation Register.

Appointment Systems

7.13 Despite the advantages of an appointments system for both doctor and patient, its use is not universal, probably because to work well it requires skilled secretarial support.

In 1964 in the U.K.,[8] prior to the General Practitioner Charter, 15% of General Practitioners used an appointment system. In 1977 the proportion had risen to 75%.

Partnerships and Personal Care

7.14 There are many benefits of group practices and partnerships of various forms. The constant contact with colleagues helps to maintain professional competence and balanced attitudes. Sharing of practice expenses is more cost-effective, and enables surgeries to be better equipped and staffed. Continuity of care is improved by providing out-of-hours cover entirely from within the practice. These advantages have been widely acknowledged, most recently in the GMS Working Party Report.

7.15 Both the McCormick Report (1974)[9] and the GMS Working Party Report (1984)[6] strongly recommended grouping of General Practitioners. Partnerships have, however, been criticised for becoming too large and impersonal. Care must be taken to ensure personal lists, so that patients can clearly identify with an individual doctor. For large numbers of Irish General Practitioners living outside cities and large towns single handed-practice is the only option.

7.16 The most recent survey shows that about 67% of Irish General Practitioners are single-handed, and the remaining 33% are either in partnership or in group practice, (GPWA Survey 1986).[3] An earlier survey had shown figures of 75% and 25% respectively. By comparision, in Northern Ireland in 1981, only 17% of General Practitioners were single handed. In the U.K. in 1952, prior to the 1966 Charter, 43% of GPs were single-handed. This figure had dropped to 12% in 1982. In 1983 almost half of all British General Practitioners were working in groups of four or more.

Expenses

(a) ***Introduction***

7.17 In Ireland there are almost no grants, loans or special subsidies available towards practice expenses, which must be met from gross practice income. The patient (or in the case of the GMS, the State on behalf of the patient) pays a 'global fee', which is intended to cover both the expense incurred in running the practice and the doctor's professional fee. The percentage of the 'global fee' devoted to practice expenses is entirely at the doctor's discretion and varies widely. The GPWA survey[3] showed that, on average, General Practitioners spend about 36% of gross income on practice expenses, with one in five General Practitioners spending in excess of 50%. For tax purposes, the average General Practitioner's expenses claim is 30% of gross practice income (based on the Revenue Commissioners recorded average ratio of expenses to income).

Thus in Ireland in 1985, the average Government contribution to practice expenses for the average panel of 877 GMS patients was IR£6874. In contrast, the U.K. position was recently summarised in the 'Green Paper'[10] as follows:"The average General Practitioner's gross income in 1985/86 is therefore expected to consist of £23,400 net income, plus £11,320 in indirectly reimbursed expenses, plus £12,400 in directly reimbursed expenses".

7.18 Expenses therefore account for more than 50% of the average British General Practitioner's gross practice income, and State spending in real terms on the infrastructure of general practice in the U.K. is approximately three and a half times the Irish level. The decline in the value of the Irish GMS fee to less than half the prevailing private consultation fee and the failure of the GMS fee to keep pace with the rise in cost of practice expenses is partly responsible for this.

7.19 Even more seriously, those General Practitioners who invest further in staff and facilities to provide a better service, can only do so at the expense of personal income. They are unable to make good their outlay by increasing fees or by claiming reimbursement from public sources. Therefore, the end result of their investment is most likely to be a better service for the patient, a more cost-effective outcome for the State, and a substantial drop in their own

net earnings. This financial disincentive to good practice is in direct conflict with the aims of this College.

7.20 What financial support, other than the global fee-per-item of service, is available to GMS doctors? The relevant grants or other forms of assistance are as follows:

Grants towards the provision of practice premises.
Locum fees.
Provision of patient records.

7.21 Direct and indirect State financial assistance is available in most sectors of the economy including industry, agriculture and tourism. In the health sector there is already massive State investment in institutional care. Considering that about 90% of all doctor/patient contacts occur in general practice it is remarkable that the State's investment in this area is tiny in the context of the total health budget.

(b) *Capital Expenses*

7.22 The capital expenditure involved in setting up and running a practice is very substantial. Financing can be arranged either by outright purchase (generally by way of a bank loan) or rent/lease arrangements. Whatever the method, the financial outgoings required to service the capital investment form the major part of the expenses of most General Practitioners.

The main capital expenses in general practice comprise:-

Premises
Furnishing and Fixtures
Office equipment
Car
Medical equipment

Of these, only practice premises qualify for assistance, in the form of a once-off grant towards the cost of new premises, or the improvement of existing premises.

The level of grants (as revised in 1981) is as follows:

Single handed practitioner	25% of total cost up to a max. of IR£1700
Partnership	37.5% of total cost up to a max. of IR£2500
Group of Three	50% of total cost up to a max. of IR£3400

(increasing by IR£850 for each additional doctor).

Given the cost of building IR£325 per sq.meter and the recommended size

of a "practice unit" (NHS "Statement of Fees and Allowances also known as the Red Book*) per General Practitioner (88 sq. metres) these grants bear no relation to the real cost of building a surgery (IR£28,500 per General Practitioner).

GP unit × 1 = 88 sq. metres × 2 = 164 sq. metres.
× 3 = 249 sq. metres × 4 = 307 sq. metres.
× 5 = 367 sq. metres × 6 = 420 sq. metres.

Table 1: The capital grants made in each of the past three years are shown in this table. This represents approximately 0.0015% of the total health budget, a miniscule overall allocation made worse by individual grants which are unrealistically low and inequitable. The number of grants disbursed provides further depressing confirmation of the low level of capital investment in general practice.

Table 1:

Health Board	Number and Total Cost of Grants Per Annum					
	1983		1984		1985	
	No.	Cost IR	No.	Cost IR	No.	Cost IR
Eastern	4	5566	3	6325	4	5620
South Eastern	2	2157	1	2250	1	2500
Southern	1	827	2	2750	Nil	Nil
Mid-Western	Nil	Nil	Nil	Nil	1	479
Western	4	6800	4	6572	3	5025
Midland	Nil	Nil	N/A	1700	Nil	Nil
North Western	N/A	4779	Nil	Nil	N/A	582
North Eastern	N/A	N/A	N/A	N/A	N/A	N/A

N/A = Not available

(c) *Non Capital (Current) Expenses*

7.23 The main items of non-capital expenditure include:

Rent, and/or rates on premises.
Car tax, insurance and running costs.
Heat and light.
Wages of ancillary staff.

*Footnote: The NHS "Statement of Fees and Allowances" refers to the size of new premises which will qualify for benefit. A practice unit consists of reception area, office, waiting room, consulting and examination room, treatment room, WC and storage space. A dispensing room (14 sq. m), Nurses' room (14 sq. m) and common room (17 sq. m) may be added.

Telephone, stationary and postage.
Loan servicing repayments for equipment etc.
Insurance, subscriptions and fees.
Books, journals, courses etc.
Locums and deputising arrangements.

Of these only certain locum expenses and limited supplies of records can be obtained from the health boards.

7.24 A small locum allowance is payable to doctors participating in the GMS. The present allowance is IR£460 per annum. The cost of paying a locum at the time of writing is approximately IR£60–£70 per day (IR£350.00 per week). Thus the locum allowance would in fact cover the cost of providing a locum for about seven days. Since the General Practitioner's contract provides for a 24 hour, 365 day commitment to the practice population the General Practitioner has to make arrangements for night and weekend cover, as well as holidays.

7.25 The expenses involved in providing a domicilary service is presumably intended to be covered by the special fees paid for house calls.

TABLE 2: Compensation for Expense of Domiciliary Visits.

Distance	The Differentials between the standard surgery fee (£3.93) and domiciliary fees. (as at October 1987)	Rate per mile for a mean journey which the differential represents.
0–3 Miles	: £1.88	63p
3–5 Miles	: £3.65	46p
5–7 Miles	: £6.27	52p
7–10 Miles	: £8.86	51p

The effective General Practitioner mileage rate is generally below prevailing public service rates, yet is expected to compensate not only for expense incurred, but for time spent travelling as well.

(d) *The NHS Position*:

7.26 The system of payment of General Practitioner expenses in the NHS is summarised in the recent "Green Paper"[10]. With the exception of those expenses which are paid on an individual basis to the General Practitioners who incurr them (Direct Reimbursement), both nett income and expenses are paid to General Practitioners through a range of fees and allowances.

Payments per General Practitioner in 1984/85 were as follows:

(i) Capitation fees: (£5,675 per GP in 1984/85): 47% of fees and allowances.

A standard annual capitation fee for each patient registered is payable at three rates, according to patients' age. These fees are supplemented where an out-of-hours service is provided.

(ii) Allowances: (£13,617: 4% of fees and allowances)

Basic practice allowance.
Seniority allowance.
Vocationally trained allowance.
Allowance for practising in a group of 3 or more.
Allowance for providing out-of-hour cover.
Allowance for having completed postgraduate training.
Rural practice allowance.

(iii) Item of Service Payments: (£4,298: 13% of fees and allowances).

A GP is entitled to a fee each time certain services are provided including immunisation, cervical smears, night calls, family planning services, and maternity care.

(iv) Direct Reimbursement of expenses: (£11,941; 50% of cost of GP expenses).*

- Payment in full for rent and rates (or a notional current market rent for practice owned surgeries).
- Extra financial help with cost of building new premises and improving existing ones.
- 70% of the salaries of certain ancillary staff up to a maximum of two per General Practitioner.
- Other direct payments including cost of drugs dispensed, salaries and expenses of trainees, and locums for sickness and study leave.

(v) Additional appointments

20% of British GPs hold a hospital assistantship posts.

*Note: This figures represents approximately 50% of the cost of expenses, the other 50% is indirectly reimbursed and included in (i) (ii) and (iii) above.

Priorities for Reform

7.27 Our examination of the present state of practice organisation in Ireland shows it to be in urgent need of reform. It is undercapitalised and inadequately funded. It is poorly housed, inadequately staffed, and of widely varying standards. Those attempting to improve their services and facilties must reduce their nett income to do so. The improvements rarely if ever result in additional practice earnings.

(a) *Patients' Needs*

7.28 Patients are entitled to expect a uniform reliable standard of service. If they are to be persuaded to reduce their demands for referral to hospital, they must have confidence that the care available in general practice is just as good.

Increasingly, they are entitled to expect their General Practitioner to anticipate their health problems, to screen them for serious illness, and to teach them how to stay healthy. They will expect to be recalled as appropriate.

(b) *Needs of Doctors*

7.29 General Practitioners must be motivated to expand and develop their services by the provision of some real incentive to do so. This may be in the form of improved job satisfaction, a more reasonable lifestyle or additional financial rewards.

Improved job satisfaction arises from the opportuntity to use to the full, existing clinical and organisational knowledge and abilities, to acquire and apply new skills, to practice a higher standard of care, to expand a range of previously neglected services (such as preventive care, surveillance, screening and health education) and to communicate with medical colleagues, thereby reducing professional isolation.

The prospect of a better lifestyle will act as a strong incentive to most General Practitioners and more especially to their families. Reforms of the system which reduce the need for family involvement in the practice and make more effective use of the doctor's time are overdue. They should include standing arrangements which guarantee time for holidays, study leave, and sickness and retirement income.

The majority of general practitioners committed to improving the services they offer are entitled to expect that they will be financially rewarded for doing so.

(c) *Needs of Government*

7.30 Government and other paymasters must be satisfied that they are getting value for money, that the existing professional and infrastructural resources of general practice are being used cost-effetively, and that as 'gatekeepers' to the hospital system General Practitioners are not being induced for whatever reason to refer excessively.

(d) *Needs of Health Service Planners*

7.31 Those charged with planning the health services of the future and meeting the WHO objective of 'Health for All by the year 2000'[11] must be satisfied that the organisation of general practice is capable of sustaining large scale developments such as the transfer of care from hospitals to the community, and the expansion of screening, prevention, and health education services. Above all, they need much more and better quality information about the use of health services at primary level, as the Tussing Report[12] and the ICGP Response[13] to it illustrated so clearly.

Strategies for Change

7.32 We make the following recommendations:

(a) Estimate in real terms the cost of providing adequate practice organisation, which should be paid independently of the fee, and not as a fixed or notional percentage of it.

(b) Establish a national agency which should be given the responsibility for surveying the capital and current spending requirements of general practice in line with overall health policy, and for supervising an investment programme and the reimbursement of general practice expenses. The present notional State contribution (£10,215,000 in 1985) must be at least trebled and even at that the annual cost of general practice expenses to the State would be less than the running costs of one major teaching hospital.

(c) Payment of all expenses should where possible be by direct reimbursement of actual expenses incurred. This could be according to pre-agreed schedules or by prior approval. However, some expenses can probably be paid only on a notional basis.

The amount of expenses to be indirectly reimbursed should be renegotiated and paid separately each year. The size of the allocation should be adjusted in the light of surveys of the amount spent in the previous year.

Reimbursement of expenses by the State could be related to practice characteristics such as the number of patients, their age and morbidity, practice location and organisation.

(d) Extend State responsibility in regard to practice expenses beyond the GMS to include all patients registered with a practice, in recognition of the savings on hospital costs when care is undertaken by the General Practitioner.

(e) Structure systems of direct reimbursement to encourage the doctor to make a greater investment in the practice. Thus, realistic regularly reviewed schedules, percentage grants, and interest free loans should be preferred. A comprehensive system of rent rebates, loan subsidies, and notional rents payable to owner occupiers, should be introduced to encourage doctors to borrow the money to build new premises or improve existing premises.

Spending on better records, staff, and premises should become an indispensible and worthwhile part of expanding services for special payments.

(f) Encourage employment of ancillary staff by having a percentage of staff salaries directly reimbursed. This should be sufficiently generous to provide for a rapid expansion in this area. The allocation should enable the employment of up to two full time equivalents per doctor. Alternatively, fees for items of service appropriately delegated to staff should be paid.

(g) Establish practice registers of all patients holding medical cards and

hospital cards and all patients contributing to Voluntary Health Insurance, by asking them to nominate their General Practitioner at the time of application and each year thereafter. Such nominations should not infringe the doctors right to refuse to accept a patient, nor should the act of nominating a General Practitioner prevent a patient from exercising his or her right to attend another General Practitioner. This list of nominations should then be supplied to each doctor in the form of a regular updated age/sex register.

(h) Devise a uniform national record for General Practice use and make it freely available. A special payment should be make for the transfer of records.

(i) Require doctors wishing to claim special services payments for screening, prevention, and the care of the chronically ill to maintain 'At Risk' and 'Disease Registers'. They should be assisted in doing so by the local community physician.

(j) Initiate pilot schemes in the use of practice computers linked to Community Care and in some cases to local hospitals, as a matter of priority.

(k) Encourage partnerships and group practices of 2–5 General Practitioners, where feasible, provided that partnership is broadly defined. These arrangements should be officially recognised in GMS contracts. While lists should continue to be personal, visiting and prescribing rates should be calculated for the partnership as a whole. Partnerships should be made more attractive by the selective use of benefits and incentives. Rights in choosing new partners should be extended. There should be added rewards where 'out of hours' cover is supplied entirely from within the partnership.

(l) In very many areas of the country partnership is not practical or possible, due mainly to geographical spread of population. Therefore make special provision including the payment of special allowances for doctors working in areas where single handed practice is the only option and the opportunities for cross cover are limited, in recognition of the greater commitment of time and effort and the highly personal care provided by these doctors.

(m) Special consideration should be given to the specific problem of practice in certain rural areas including the provision of suitable practice premises, appropriate secretarial and other ancillary staff, necessary communication systems, medical emergency equipment and appropriate storage facilities for rural dispensing where appropriate.

8

REFORM OF PRESCRIBING

Introduction

8.1 Generic substitution has been proposed as a cost-saving method. The Irish College of General Practitioners would have to be assured regarding a number of quality issues relating to such substitutions before any such proposal could even be considered.

8.2 Limited lists have been operated both in hospitals[1] and in general practice[2] without hardship to either doctors or patients. In order to compile a limited list appropriate to general practice there would have to be the fullest consultation with this College. The operation of the list would need to be closely monitored and incorporate a flexible system for making appropriate additions and deletions. There would also need to be flexibility in permitting exceptions in special circumstances. It must be remembered that a limited list would not prevent the General Practitioner from prescribing items not on the list; it would, however, mean that the cost of such items would have to be borne by the patient. There seems no reason why any limited list introduced should not apply to all categories of eligibility, and the College would oppose different 'lists' for those attending outpatient departments.

8.3 That is not to say that prescribing is not a quality issue. It certainly is, but we have come to the conclusion that the real reforms of prescribing must address the wide variation between individual prescribers, the appropriateness of individual prescriptions and their duration and the problems of polypharmacy. These questions can only be answered by peer review and by General Practitioners as part of their work. Those who undertake such review should be paid for doing so.

8.4 A significant improvement in prescribing quality and cost could result not from reform of prescribing per se but from a change in the system of payment for consultations for minor illness. The General Practitioner's initial decision to prescribe will be determined by many factors on both the doctor and patient side of the consultation. Doctors will be heavily influenced by their training, orientation and knowledge of alternatives to prescribing, such as physiotherapy or counselling and their availability. They will also be influenced by the consultation rate, the time available and their perception of the patient's expectations. The patients' expectations in turn will be formed perhaps long before the consultation by influences such as family, friends and the media. Previous visits to the doctor will be amongst the most important influences on patient expectation.

8.5 All proposals, which offer bonuses to doctors, in proportion to drug savings are ethically unacceptable. It has been suggested that a proportion of savings made in drug expenditure could be used to finance General Practitioner pensions. We totally reject this 'keep the change' suggestion. Appropriate and economic prescribing is not only desirable but is also an integral part of quality medicine. It deserves doctors attention and effort throughout their professional life for its own sake. In this way rational prescribing will be moulded in the best interests of the patients who are our 'raison d'etre'.

Present Position: General Practitioners

8.6 For General Practitioners the present position can be summarised as follows:

(a) They enjoy the freedom to prescribe any pharmaceutical preparations they wish.

(b) They must consider the category of eligibility of the patients for whom they prescribe and the cost implications for the individual, of every prescription.

(c) They are discouraged from prescribing more than one month's supply at a time for GMS patients by both the G.M.S. (Payments) Board and the Pharmacists.

(d) They must consider the medico-legal hazards of prescribing.

(e) They receive regular feedback on the volume and cost of their GMS prescribing and how these compare with health board and national averages. This information is purely numerical and cost orientated. It tells nothing about the quality of prescribing in terms of the need for and effectiveness of each prescription. No feedback is available on private prescribing.

(f) They must bear the full cost of keeping up to date in the rapidly changing field of therapeutics (the only exception being the free distribution of the 'Drugs and Therapeutics Bulletin').

(g) They vary so enormously in their prescribing habits as to suggest that some prescribing is likely to be excessive, inappropriate or inadequate.

(h) They dispense drugs to their patients in rural areas. This is a most important factor in the provision of a quality service in those areas.

Present Position: Patients

8.7 Patients are divided into three categories of eligibility.

(a) ***Category* 1**

(i) Includes those who in the opinion of the C.E.O. of the health board of the area in which they reside are unable to afford General Practitioner services for themselves and their dependants. Income guidelines are issued periodically.

(ii) With the exception of antacids, minor analgesics, antitussives, vitamins, tonics and some antihistamines practically all medicines are available free of charge on presentation of a GMS prescription to a participating pharmacist.

(iii) The list of excluded items contains many frequently prescribed inexpensive and safe preparations. There is therefore some pressure on the General Practitioner to prescribe more elaborate, more expensive and perhaps potentially more dangerous alternatives which are free to the patient.

(iv) Repeat prescriptions are obtained once per month by further attendance with the doctor.

(v) No charge, either permanent or reimbursable, is levied at any stage either for the visit to the doctor or for the receipt of the prescribed medicines.

(vi) Patients do not know the cost of their prescriptions.

(vii) There is no ceiling on the number of prescriptions or total cost of prescriptions which a patient may receive.

(viii) With the exception of the reservations already expressed concerning the list of excluded items, patients can obtain optimum therapeutic care without regard to cost.

(b) ***Category 2***

(i) Includes persons who are not entitled to a medical card who earned less than £15,500 in the year ended 5th April, 1987.

(ii) Prescriptions must be paid for at time of receipt.

(iii) Expenditure in excess of £28.00 per month per individual plus dependants, is reimbursable under the drug refund scheme.

(iv) All prescribed medicines are included in the refund scheme.

(v) Patients face substantial outlay on prescriptions, often at a time when their income is reduced due to illness.

(vi) The cost of both the doctors' fee and that of the prescription acts as a disincentive to this marginal income group seeking medical advice and in attending for follow up. As medical costs rise this disincentive strenghtens.

(c) ***Category 3***

(i) Includes persons who earned in excess of £15,500 in the year ended 5th April, 1987 and who have paid their health contributions.

(ii) Entitlement to drug refund scheme is as for Category 2.

(d) ***Long Term Illness and VHI Schemes.***

In addition to these three categories there are two other schemes of importance in the consideration of prescribing.

(i) The long term illness scheme provides that persons in all categories suffering from certain illnesses can obtain free of charge any prescriptions for their conditions. The following illnesses are included:

Mental Handicap	Mental Illness under 16 yrs. old.
Phenylketonuria	Cystic Fibrosis
Spina Bifida	Hydrocephalus
Diabetes Mellitus	Cerebral Palsy
Epilepsy	Multiple Sclerosis
Muscular Dystrophies	
Parkinsons Disease	
Acute Leukaemia	

(ii) For V.H.I. members expenses for out-patient services are reimbursable after a deductable of £170.00 per family or £105 per individual per annum. This includes reimbursement of up to £28.00 per month per family for prescription costs. It is clear that once the deductable has been reached the disincentive to seeking medical care including prescriptions diminishes.

Present Position: The State

8.8 Faced with a difficult budgetary situation the State is examining health expenditure to identify areas with potential for savings. The ingredient cost of prescriptions in the GMS has risen from £25.6 million in 1980 to £56.3 million in 1986. The cost of the drug refund scheme has risen from £7.1 million in 1980 to £7.6 million in 1984. This conceals the fact that expenditure rose to £11.6 million in 1982 and has been reduced to the current level by raising the threshold for entry to the scheme from £8 per month in 1980 to £28 per month in 1984. It has been suggested that in Ireland, as in many countries throughout the world, this inexorable rise will be confronted.

The *State* has several options (which we recognise but do not necessarily endorse)–with regard to those individuals and prescriptions for which it is currently paying.

(a) The Limited List: Positive.
A list of medicines for which the State is prepared to reimburse the pharmacist. This could exclude entire categories of medicines and would reduce the range of choice within categories.

(b) The Limited List: Negative.
A list of medicines for which the State is not prepared to reimburse the pharmacist.

(c) Generic Substitution by the Pharmacist.
The State would reimburse the pharmacist only the cost of the generic equivalent of the proprietary product on the doctors prescription.

(d) There are other cost saving measures the State could consider taking. For instance, a prescription charge could be introduced for Category 1 patients. Withdrawal from all funding of prescriptions is also possible. With regard to Category 2 and 3 patients, the State could also further raise the threshold of expenditure at which reimbursement commences.

Priorities for Reform

8.9 In ideal circumstances each prescription should be:

(a) Necessary and clinically appropriate.

(b) Include the minimum number of items.

(c) For the shortest possible duration.

(d) Regularly reviewed to assess efficacy, side-effects and, in the case of repeat prescriptions particularly, continued need and compliance.

(e) For a product of assured quality.

(f) Acceptable to the patient (in terms of side-effects, palatability, convenient form and dose).

(g) Affordable without hardship to the patient.

(h) 'Value for money' for whoever must meet the cost.

Strategies for Change

8.10 We recommend the following:

(a) Provide Vocational Training for all those entering general practice.

(b) Promote an attitude of life-long learning amongst established General Practitioners.[3]

(c) Provide effective continuing education particularly that which includes peer review of prescribing decisions together with the time and opportunity to avail of it. By peer review is meant General Practitioners meeting together in C.M.E. groups. This should lead to rational prescribing policies for practices and even for whole areas.

(d) Encourage consultations which include counselling, patient education, and general advice.

(e) Conduct public health education programmes.

(f) Provide regular flow of unbiased drug information to prescribers, including reminders as to cost.

(g) Provide more specific feedback to prescribers[4] designed to assist them in pinpointing personal prescribing idiosyncrasies.

9

MANPOWER AND TRAINING

Manpower: Present Position

9.1 Neither the total number of General Practitioners, nor the rate at which their numbers are changing, are accurately known. In 1986 the total was estimated[1] to be 2200, of whom 1512 (69%) had contracts to provide General Medical Services. In 1981 the total number of General Practitioners was estimated to be 1821,[2] and the number providing General Medical Services to be 1418[3]. This represents an annual increase of 4% in the total number of General Practitioners, and of 1.3% in those in the G.M.S. Both these rates of increase are considerably greater than the annual population growth rate of 0.6%[4].

9.2 Entry into private general practice, unlike that to all other branches of medicine, remains open to any fully registered doctor. Entry to the G.M.S. has, until recently, been possible for any doctor who had practised for more than five years in one area. In the two years 1985 and 1986, 101 doctors entered the G.M.S. by this route, as compared to 39 who entered by direct competition.

9.3 Our studies of numbers entering practice over the last five years show that there is serious over-doctoring, particularly in some urban areas. This will undermine the service.

Manpower: Priorities for Reform

9.4 The date is fast approaching when some modification of the traditional freedom to 'put up a plate' will be required. General practice cannot sustain standards and remain at the same time the last refuge for those excluded by other disciplines.

9.5 There must be an equitable system for selecting candidates for general practice.

Manpower: Strategies for Change

9.6 We make the following recommendations:

(a) Follow up the recent Manpower study carried out by the College with a detailed annual review of the manpower requirements of Irish general practice. Include a review of the available training posts, and an investigation of the current level of training of Irish General Practitioners.

(b) Having regard to all the variables make an attempt to frame a coherent Manpower plan.

(c) Review methods of entry into the G.M.S.

(d) Ensure that all disciplines share the responsibility of providing a reasonable career structure for those already in training.

Training: Present Position

9.7 The present lamentable state of training opportunities for general practice also requires urgent attention. Training is made all the more important by the minimal exposure to general practice at undergraduate level. We take the view that no one entering practice should do so untrained.

9.8 There are at present 28 recognised vocational training posts per annum. The number entering practice each year is in excess of 100[5]. While some are trained in the U.K., the majority of those entering are forced to rely on what has been called self-structured training. This really means time spent in a series of six month hospital appointments of variable relevance and sometimes little educational value.

9.9 A major obstacle to any system of vocational training, even if there were adequate places, is the absence of any career structure or rational method of recruitment to the G.M.S. for recently trained General Practitioners. There are, in fact, incentives for doctors to minimise training in order to enter, as quickly as possible, a job market where the number of opportunities is rapidly

diminishing. This also discourages Non Consultant Hospital Doctors from going abroad to work in general practice in other health care systems, or from providing their much needed medical services to the developing world.

Training: Priorities for Reform

9.10 All medical students, particularly those who do not intend to become General Practitioners, should be given the opportunity to learn about general practice.

9.11 Expansion of the number of training places to at least 75 per annum must be an urgent priority.

Training: Strategies for Change

9.12 We make the following recommendations:

(a) Establish Chairs of General Practice in all medical schools with full clinical departments. General practice must come to share a central place in the undergraduate curriculum and in the final medical examination.

(b) Expand Vocational training rapidly to 75 places per annum.

(c) Invest in trainers' courses and training practices, expand the existing ones, and create new training schemes.

(d) Provide incentives to established General Practitioners to become involved in the training process.

(e) Make realistic formal commitment of hospital Non Consultant Hospital Doctor posts to General Practitioner training as 50% of those in hospital training will enter general practice in any event.

(f) Ensure flexibility in structures of training. Rigid adherance to the present system would not allow the potential of alternatives to be explored.

Overproduction of Medical Graduates

9.13 The current requirements for recruitment to all branches of medicine are given in Table 1.

Table 1.

Estimated manpower requirements to maintain current patient/doctor ratios.

Consultants	35
Community Medicine	12
Defence forces, occupational and academic medicine	10
General practice	75
Allowance for wastage, leave of absence etc.	70
Total	202

The figures for general practice refer to the total number of posts. An increase in the Consultant/Non Consultant Hospital Doctor ratio is recommended by Comhairle na nOspideal, and this would bring the annual requirement for graduates to 220. As the present rate of production of medical graduates is approximately 442 per annum (1987), of whom 325 are Irish nationals, there is a continuing surplus of about 120 graduates per annum. Steps should be taken to remedy this over-production, as there remains a large number of medical graduates for whom provision will have to be made by the profession as a whole, and not just by general practice.

REFERENCES

CHAPTER 2

1. Policy documents published by the Irish College of General Practitioners on the organisation of health care:
   Response to The Report of the Working Party on the General Medical Service.
   Practice Expenses – A Position Document, 1985
   Discussion Paper in response to The Psychiatric Services–Planning for the Future, 1985.
   Proposals for a Modified Fee and Standards of Practice–A Discussion Paper, 1985.
   Response to Irish Medical Care Resources–An Economic Analysis, 1986.
   Submission to the Department of Health on Public Health Nursing Services in Ireland–A Discussion Document, 1986.
   Submission on the Care of the Elderly.
   Submission on Health–The Wider Dimensions.
   Submission to the Commission on Health Funding.

CHAPTER 3

1. *The Psychiatric Services–Planning for the Future*, Report of a Study Group on the Development of the Psychiatric Services, Dublin, 1984.
2. Abel Smith B., *Value for Money in Health Services*, London, Heinemann, 1976.
3. *Report of the Working Party on the General Medical Services*, Dublin, 1984.

CHAPTER 4

1. *Irish Medical Care Resources: An Economic Analysis*, No. 126, E.S.R.I., Dublin, 1985.
2. *Second Report*, Council for the Postgraduate Medical and Dental Education, 1977.
3. *Career Guidance Medical Manpower*, Postgraduate Medical and Dental Board, May 1985.

4. *Report of the Working Party on the General Medical Services*, Dublin, 1984.
5. Mr. Barry Desmond T.D., Minister for Health, in response to a Dail question, 22nd January, 1986.
6. *Department of Health statistical information relevant to the Health Services*, 1983, Section General Practitioner, p. 41, Section J, p. 73.
7. *Department of Health statistical information relevant to the Health Services*, 1978, Section G, p. 34, Section I, p. 64.
8. *Health and Personal Social Services, Statistics for England*, H.M.S.O., 1982.

CHAPTER 5

1. Maynard, Marinker and Pereira Gray, Br. Med. J. 1985, 292, p. 1438–1440.
2. Barry Desmond T.D., Irish Medical Times, July, 1986.

CHAPTER 6

1. *Report of the General Medical Services (Payments) Board*, Dublin.
2. Fry J., *Present State and Future needs in General Practice*, R.C.G.P. London, 1983, p. 48.
3. Marsh, G.N., *Home Visiting*, Br. Med. J. April, 1968, 1972.
4. *Report of the Working Party on the General Medical Services*, Dublin, 1984.
5. Fry J., *Present State and Future Needs in General Practice*, Royal College of General Practitioners, London, 1983, p. 44.
6. Johnson and Johnson, *Cerviscan*, Irish Medical News, 13th March, 1986.
7. *Public Health Nursing Services in Ireland–A Discussion Document*, Department of Health, Dublin, 1986.
8. Report of a study group on the development of the Psychiatric Services, *The Psychiatric Services–Planning for the Future*, Dublin, 1984.
9. Fry J., *Present State and Future needs in General Practice*, Royal College of General Practitioners, London, 1983, p. 24.
10. Hasler J., Journal of R.C.G.P., 1985, 35, p. 121.
11. Hasler J. and Schofield T., *Continuing Care–The Management of Chronic Disease*.
12. Stott N., *Primary Health Care*, Springer Verlag.
13. Oliver B., Meagher N., Cole M., *The Present State of General Practice in the Republic of Ireland*, Modern Medicine of Ireland (supplement), 1984.
14. *Department of Health statistical information relevant to the Health Services*, 1983, p. 18.
15. Fry J., *Present State and Future needs in General Practice*, R.C.G.P., London, 1983, p. 18.

16. Shannon W., *Aims and Objectives of Vocational Training for General Practice in Ireland*, I.C.G.P., 1985.
17. *Department of Health/Postgraduate Medical and Dental Board joint working group on Vocational Training for General Practice.*
18. *E.E.C. Directive on specific training in general medical practice*, 1986.
19. Fry J., *Present State and Future needs in General Practice*, R.C.G.P., London, 1983, p. 40.
20. *First Report*, The Postgraduate Medical and Dental Board, March 1980–1985, Dublin, 1985.
21. *Report of the Working Party on the General Medical Services*, Dublin, 1984.
22. *The Principles of Quality Assurance*, Euro Reports and Studies 94, W.H.O. Regional Office for Europe, 1983.
23. *Qualitative and Quantative Evaluation of the practice of general medicine*, U.E.M.O., Interim Report No. 2, 1984.
24. *Quality improvement by quality assessment in general practice*, The New Leeuwenhorst Group, 1986.
25. *Quality in General Practice*, Policy Statement No. 2, R.C.G.P., London, 1985.

CHAPTER 7

1. *A Charter for the Family Doctor Service*, British Medical Association, 1966.
2. Oliver B., Meagher N., Cole M., *The Present State of General Practice in the Republic of Ireland*, Modern Medicine of Ireland (supplement), 1984.
3. Flanagan M., General Practitioners Wives Association, *Survey of Practice Organisation in Ireland*, Irish Medical News, 6th March, 1986.
4. Fry J., *Group Practice and Health Centres*, Update vol. 8, 1983.
5. Fry J., *Present State and Future needs in General Practice*, R.C.G.P., 1983.
6. *Report of the Working Party on the General Medical Services*, Dublin, 1984.
7. Cooper R.F., *Do Most Practices Have An Age/Sex Register?*, Br. Med. J. 1985, 291, p. 1391.
8. Arber S. and Sawyer L., *Appointment Systems; Do they Work?*, Br. Med. J. 1982, 284, p. 478.
9. *Report of the Consultative Council on General Medical Practice*, Dublin, 1974.
10. *Primary Health Care*, H.M.S.O., London, 1986.
11. *Health for all by the year 2000*, World Health Organisation, Copenhagen, 1985.
12. *Irish Medical Care Resources: An Economic Analysis*, No. 126., E.S.R.I., Dublin, 1985.
13. *A response to Irish Medical Care Resources: An Economic Analysis*, I.C.G.P., Dublin, 1986.

CHAPTER 8

1. Sandler D., Cannon J., *The Limited List*, Br. Med. M., 1985, 290, p. 1746.
2. Harding J.M., Modell M., Freudenberg S., et al, *Prescribing: The Power to set limits*, Br. Med. J., 1985, 290, p. 450.
3. Harris C.M., Fry J., Jarman B., et al, Journal of R.C.G.P., 1985, 35, p. 284.
4. *Quality in Practice*, Bulletin from the R.C.G.P., 1985, 35, p. 284.

CHAPTER 9.

1. *Current Manpower Issues in General Practice–A Discussion Document*, I.C.G.P., 1988.
2. Oliver B., Meagher N., Cole M., *The Present State of General Practice in the Republic of Ireland*, Modern Medicine of Ireland (supplement), 1984.
3. *Annual Reports*, General Medical Services (Payments) Board, Dublin.
4. *Census of Population in Ireland*, Dublin, 1986.
5. *Second Report*, Council for Postgraduate Medical and Dental Education, Dublin, 1977.

APPENDIX 1

CATEGORIES OF ELIGIBILITY

CATEGORY 1

Includes those who in the opinion of the C.E.O. of the Health Board of the area in which they reside are unable to afford General Practitioner services for themselves and their dependents. Income guidelines are issued periodically.

CATEGORY 2

Includes persons who are not entitled to a medical card who earned less than £15,500 in the year ended 5th April, 1987.

CATEGORY 3

Includes persons who earned in excess of £15,500 in the year ended 5th April, 1987 and who have paid their health contributions.