Competition in Primary Care in Ireland

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Introduction

In this paper, we first identify the tensions around seeing healthcare as a "market", and therefore a context in which competition principles can apply. We then look at one particular aspect of primary care in Ireland – GP services – and describe how the Irish Competition Authority was able to identify a number of ways in which competition between GPs could be improved, to the benefit of both patients and doctors.

Healthcare and markets – mutually exclusive ?

If it is legitimate to speak of economics and healthcare in the same breath, is the same true of healthcare markets ? In other words, can health care really be a *market* in the conventional sense ?

To someone lying on a trolley in an overcrowded A&E department or waiting in a long line in a GP surgery, the notion that he or she is a consumer of a product sold in a normal marketplace seems far from reality.

But the fact is that, in such situations, consumers (or someone on their behalf) are buying something – in this case a bundle of professional services. Someone – the hospital, the medical staff and so on, is selling the bundle. Someone is also paying for these services – the individual involved, a private insurer, or the State – or indeed perhaps combinations of all of them. There are supply and demand forces, as you would expect to find elsewhere.

So what makes it difficult to apply concepts of normal market behaviour to health care ? One main difficulty lies in the "black-and-whiteness" of the arguments

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which arise, and the distrust, by the proponents of each, of the arguments of the other.

On one side, there are those who argue that a person's life and health are simply too important to leave to the vagaries of market forces, and who maintain that markets have no role to play in a properly functioning health care system. Others argue that without the application of market principles, health care – and particularly the cost of it – is simply a bottomless pit into which taxpayers, insurers and other funders throw ever-increasing amounts of GNP.

Adopting either of these polarised positions makes absolutely no contribution to the debate about health care reform. No one believes that all aspects of the delivery of medical care services should be left totally to the operation of a free market. On the other hand, few people would claim, either, that the delivery of medical services – even in a fully-integrated public system – can operate without some elements of market-type discipline, including incentives to encourage efficiency, value for money, and innovation.

It is not simply a struggle between a public system and a purely private one, or between a totally regulated market and a purely competitive one. As in so many areas of public policy, the challenge is to move away from these extremes, and to recognise that the common ground lies between the two.

The key question is where the intersection of the two approaches ought to lie, and who should do what, and under what conditions. To put this in economic terms, it is no more true to say that the classic perfectly competitive market exists in healthcare than it is to claim that health service provision is a purely social good, a natural monopoly in which competition has no role.

The second difficulty in seeing health care as an economic market – and what does distinguish it from many other economic sectors – is the diffuse nature of the factors affecting conventional market forces –

- In most cases, the consumer of health care services does not fully determine his or her own demand, due to the information asymmetries involved. This is largely determined – or at least significantly influenced – by doctors.

- Neither does the consumer, in most cases, pay for services directly, this role normally being taken up by the State or by private insurers. Since insured consumers do not face the full cost of a particular intervention at the time, their incentives to curtail their demand are weakened.

- Whether insured or not, private consumers will be willing to pay significant amounts for the treatment of diseases, particularly acute disease states and, as a result, will not be significantly influenced by the level of prices and fees charged.

However, none of this is to say that seeing health care as a market – and how a more pro-active competition policy might apply within that market – is beyond us. It is simply that it is more of a challenge to establish where the competition "space" actually is.

The role of competition advocates is to persuade the relevant legislators and public bodies either that the presence of markets and the competitive pressures that go with them can improve outcomes, or that regulations which confer market power on producers should be removed or replaced by measures less restrictive of competition.

The most recent work by the Competition Authority in this area in Ireland was our detailed Market Study of competition among general medical practitioners (GPs).[4] We wanted to see whether competition among GPs could be made to work more effectively for the benefit of patients.

The Authority's aim was to:

- identify any unnecessary restrictions on competition among GPs;
- highlight the impact of these restrictions on patients; and
- develop workable proposals to improve competition in the profession.

The remainder of this paper outlines our key findings, highlights the recommendations we have made for change and reports on the initial reaction to our proposals.

[4] Copies of the report are available at www.tca.ie/EN/Promoting-Competition/Market-Studies/Professions/General-Medical-Practitioners.aspx.

GPs in Ireland: A quick overview

Before we look at how GPs in Ireland compete, a quick profile of the profession might be useful.

Distinctive features of general practice in Ireland

The delivery of primary care in Ireland differs in many important respects from that of the UK or of continental European countries:

- **Lack of universal healthcare:** There is no universal access to free GP services in Ireland. The vast majority of people (66%) attend their GP as private patients, paying an average of £42 per consultation.[5]

  The remaining one-third of the population are public patients. Public patients qualify for free GP services under the Government's General Medical Services (GMS) scheme. Access to the scheme is means-tested and restricted to people with low incomes or chronic illnesses.

- **Mixed private/public system:** The vast majority of GP practices in Ireland treat both public and private patients. The services provided to both categories of patient are identical – the only difference relates to who foots the bill.

- **Independent GP contractors:** Most GPs in Ireland are self-employed professionals.[6] The State contracts individual GPs to provide services to public patients in their area. Public patients are free to register with any GP in possession of a State contract.

Key players in Irish general practice

The main organisations involved with general practice in Ireland are:

- **Department of Health and Children:** The Department of Health and Children is responsible for setting overall health policy and allocating budgets for primary care.

[5] Sterling amounts quoted in this paper have been converted from euros using the exchange rate in operation on 23 August 2010 (€1 = STG£0.816). Figures have been rounded for presentational purposes.
[6] Some GPs work as employees in GP practices.

- **Health Service Executive ("HSE"):** The HSE is the national state body responsible for meeting Ireland's health and social care needs, and provides services in hospitals, health facilities and communities across the country. In the present context, it –

  - funds the system under which individual GPs are contracted to provide free GP services to public patients,
  - allocates funding for GP training programmes[7], and
  - is currently engaged in the roll-out of a programme which would see GPs operating as part of wider primary care teams throughout Ireland.

- **Irish Medical Organisation ("IMO"):** The IMO is a professional representative body for medical practitioners. It is involved in all stages of the process through which State contracts are awarded to GPs to treat public patients.

- **Irish College of General Practitioners ("ICGP"):** The ICGP is a private body established to provide professional support for GPs through the provision of education, training and research programmes. It is the sole body recognised by the Irish Medical Council (the statutory regulator) for the accreditation of specialist training in general practice. It controls the gateway for those wishing to become a GP in Ireland, albeit at the discretion of the Medical Council.

Competition limited by an overall shortage of GPs

There are 2,800 GPs in Ireland, serving a population of 4.5million, a ratio of 0.6 GPs per thousand population. This is very low compared to continental European countries. It is lower even than the UK level, which is itself ranked near the bottom in international comparisons of GP supply (see Table 1 for details).

[7] Doctors admitted to GP training programmes in Ireland are employees of the HSE while training and receive a salary linked to hospital doctor salary scales.

Table 1: Number of GPs (per thousand of population), International Comparisons, 2005.

Country	Number of GPs(per thousand of pop)
Germany	1.0
US	1.0
Italy	0.9
Spain	0.9
UK	0.7
New Zealand	0.7
Ireland	**0.6**

Source: OECD Health Data 2007.

Several recent reports have identified the shortage of GPs in Ireland as a major policy concern.[8] Supply shortages impact directly on the level of competition in the sector. Competition cannot operate effectively if there are not enough GPs to offer patients a choice of GP in all areas. The first essential step in any strategy to increase competition among GPs in Ireland must therefore be to ensure an adequate supply of GPs.

The Government has taken the first step towards addressing the shortage of GPs in Ireland by significantly increasing the intake of students into medical colleges. The number of Irish and EU students graduating from Irish medical colleges is set to more than double over the next few years, with 651 doctors due to graduate in 2014 compared to just 315 graduates in 2005. It will take a further four years before this feeds through into an increase in the number of doctors graduating as fully-trained GPs. The extent to which the additional numbers move into general practice, as opposed to other medical specialties, is also critically dependent on the number of places made available in GP training programmes, which are funded by the State.

[8] See, for example, Layte R. (editor), *Projecting the impact of demographic change on the demand for and delivery of healthcare in Ireland,* ESRI Research Series Number 13, October 2009; Fás/Expert Group on Future Skill Needs, *A Quantitative Tool for Workforce Planning in Healthcare: Example Simulations,* June 2009.

Ireland's Primary Care Strategy

Government health policy in Ireland aims to increase the focus on primary care, moving treatment away from hospitals into the community. As part of this strategy, the HSE is seeking to reorganise the delivery of primary care in Ireland through the development of Primary Care Teams. The intention is that these would provide patients with "one-stop-shop" access to a range of health care providers including GPs, psychologists, physiotherapy, public health nurses, etc. By the end of last year, 27% of GPs in Ireland (755 GPs) were participating in 184 Primary Care Teams.

The modern Irish GP

- ***Highly-trained professionals working in multi-partner practices:*** It takes ten years to qualify as a GP in Ireland – six years in medical school followed by four years of specialist training in general practice.

  The traditional single-handed GP practice is on the way out and an increasing number of GPs operate in multi-partner practices or as part of wider primary care teams. In 2005 (the latest year for which figures are available), almost half of all GPs in urban areas (48%) worked in practices with two or more practitioners. Practices in rural areas are smaller, but here too there is a movement away from sole practitioners, with 45% of rural GPs working in practices with two or more practitioners.[9]

- ***Increasing numbers of female GPs:*** Recent decades have seen a significant feminisation of the profession (70% of those who graduated as GPs between 1997-2003 were female, compared with just 6% in 1975-1979.)[10]

  Increase in part-time working: The number of GPs engaged in full-time clinical general practice is falling. Only 43% of those who graduated from GP training programmes in 1997-2003 were engaged in full-time practice. This trend is visible among both male and (to a greater extent) female GPs. It has important implications for the supply of GP services in the future, with more GPs being needed simply to maintain existing levels of care.

[9] O'Dowd, T. M. O'Kelly and F.O'Kelly (2008), *Structure of general practice in Ireland 1982-2005.*
[10] O'Kelly F., M. O'Kelly, A. Ni Shuilleabhani and T. O'Dowd (2008), *A National Census of Irish General Practice Training Programme Graduates 1997-2003.*

- ***Incomes:*** A recent OECD report suggests that Ireland ranks alongside the UK, US, Germany and the Netherlands in terms of GP remuneration. These five countries are all in the top quartile of OECD countries. Countries in the bottom quartile include Sweden, Finland and Australia (See Table 2 below).

Table 2: Remuneration of GPs, International comparisons

Top Quartile:	Ireland
	UK
	US
	Germany
	Netherlands
Second Quartile:	Austria
	Canada
Third Quartile:	France
	Belgium
Bottom Quartile:	Sweden
	Finland
	Australia

Source: Achieving better value for money in healthcare, *Table 1.1.* OECD 2009,

In the final years of their training, trainee GPs in Ireland are paid a total of £59,000 - £67,000 per annum.[11] Qualified GPs working as employees in GP practices would typically earn well in excess of these figures.

Most self-employed GPs earn a mixture of fee income from private patients and income from the State for services delivered to public patients. GPs receive an average of £53 for every visit made by a public patient (compared with an average of £42 for every visit made by a private patient). In 2008, the average payment made to GPs contracted by the State to provide services to public patients was £180,000.[12] No details are available on the income earned from private patients.

- ***Patient satisfaction:*** Patients generally report high levels of satisfaction with GP services.[13] There is no significant difference in the level of satisfaction reported by public and private patients.

There are, however, concerns about a shortage of GP services in certain areas (notably in certain areas of north county Dublin, in the rapidly-growing commuter belt areas around Dublin and in certain rural

[11] These 2008 figures include both the basic salary of GP trainees and supplementary allowances paid.
[12] This figure of £180,000 represents the payment to the practice and does not necessarily accrue to the individual contracted GP. It may include payments received for patients treated by other GPs employed in the practice. See page 8 for details.
[13] *Insight 2007: Health and Social Services in Ireland – A Survey of Consumer Satisfaction,* HSE.

blackspots). Roughly one in five patients feel that they are not given enough time to discuss their medical/health problem with their GP.[14]

Private patients are concerned about the cost of GP visits. There is no State regulation of the price GPs charge private patients. GPs are free to charge whatever they feel the market will bear.

Restrictions on competition among GPs in Ireland: What the Competition Authority found.

The absence of universal access to free GP services in Ireland means that Irish GPs are exposed more directly to competition than many of their European counterparts. Competition has, though, traditionally been muted by a combination of regulatory restrictions[15] and professional norms (which tended to frown on the notion of competing for patients).

We found that competition was further restricted by elements of the State contract system through which GPs are contracted to provide services to public patients, and by restrictions on entry to specialised GP training programmes which limit the number of new GPs graduating.

We identified three areas where competition between GPs was being restricted:

1. Obtaining a State contract to treat public patients;
2. Entry to GP training programmes; and
3. Advertising of GP services.

Problem Area 1: State contracts to treat public patients

Importance of the State contract

Obtaining a State contract to treat public patients is vitally important to newly-establishing GPs. Without a contract, GPs who want to set up in practice are restricted to treating private patients only. They are denied access to one-third of the market (accounting for half of all GP visits) and miss out on the significant financial benefits which accrue to contract holders.

[14] 17% of private patients and 22% of public patients feel that insufficient time is provided for GP consultations. *Insight 2007, op. cit.*
[15] For example, GPs were prohibited, until recently, from advertising for private patients.

Contracted GPs receive a variety of payments under the GMS:

- *Capitation payments:* GPs receive an annual payment for every public patient on their list, regardless of how many visits a patient makes. Payments are weighted to take account of patients' age and gender and of the distance to their home from the GP's surgery.

- *Practice Allowances:* Contributions are made towards the cost of providing *locum* cover for annual leave, study leave, maternity leave and sick leave. Grants are provided towards the cost of practice premises. Practice support allowances are provided to assist with the cost of hiring secretarial and nursing staff. These allowances vary according to the size of the GP's list of public patients.

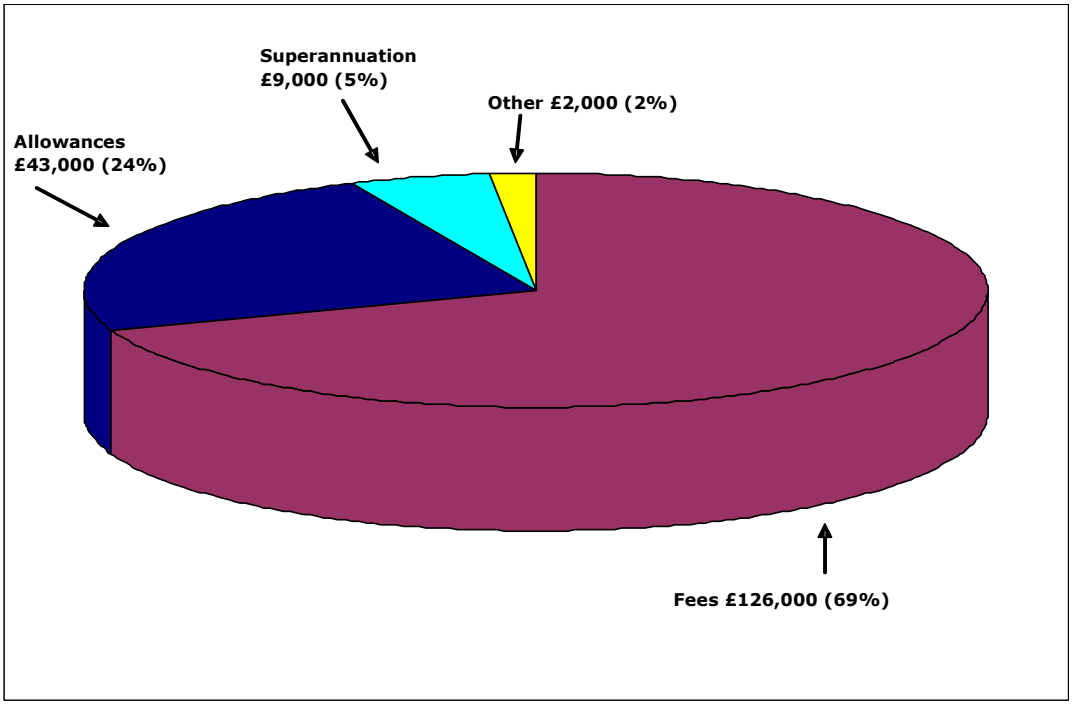
- *Superannuation:* The HSE contributes to the superannuation fund of contracted GPs.

- *Other Fees and Allowances:* GPs receive fees-per-item for a range of specified services, such as suturing and excisions. Additional payments are made to GPs in certain remote or rural areas where population densities do not support large practices.

The average payment per GMS-contracted GP in 2008 was £180,000. This figure represents the average income of the entire practice under the GMS. Many contracted GPs employ other GPs within their practices. Qualified GPs who do not have a GMS contract are entitled to treat public patients within the practice, and under the supervision, of a contracted GP. The contract-holder is reimbursed for all public patients on his/her list, regardless of which GP within the practice treats them. Like any other business, they must pay staff costs (including the cost of GP employees) out of their total business income.

Figure 1 shows the composition of payments to GPs under the GMS. The biggest element of payments (69%) relate to capitation fees and other fees for services provided to patients. About a quarter (24%) of the monies relate to practice support allowances. Contributions to the GPs' superannuation fund account for a further 5% of payments.

Figure 1: Average payment per GMS-contracted GP 2008, £180,000



Source: HSE, Primary Care Reimbursement Service, *Financial and Statistics Analysis 2008*

Payments to contracted GPs effectively subsidise the entire practice of the contract holder, making it very difficult for non-contracted GPs to compete on price for private patients. It is not surprising in these circumstances to find that only a tiny proportion of GPs in Ireland opt to set up a private-only practice.

How are contracts awarded?

In 2008, three out of every four GPs in Ireland held a GMS contract. Of course, that means that one in four GPs does not. Indeed, only 22% of recently-qualified GPs hold a contract.[16]

Qualified GPs are not automatically entitled to apply for a contract to treat public patients. Intending applicants must wait until the HSE advertises a GMS post in a particular area. If they are successful in being awarded the contract, following an interview and assessment process, they must then set up practice in that location, and they receive a "list"[17] of public patients for the practice.

[16] Figures relate to GPs who qualified within the previous two years. Source: ICGP Survey 2009.
[17] 42% of GPs have a list of between 501-1000 public patients. The maximum list size permitted is 2,000 public patients.

The HSE awards GMS contracts in three situations:

- Retirement, death or resignation of an existing GMS post-holder;
- Creation of a position as an *Assistant with a view to Partnership* within an existing GMS-contracted practice; or
- Creation of a new GMS post.

New posts may be created in situations where the HSE, following consultation with the IMO, has identified a clear shortage of GP services for public patients in a particular area. The criteria used to determine whether a new post is required are:

- **Access**: Ensuring that all public patients in a given location have access to GP services;
- **Choice**: Ensuring that public patients have a reasonable degree of choice in selecting a GP; and
- **Viability**: Ensuring that "*due regard is given to the viability of practices in the area".*[18]

Existing GMS posts are occasionally suppressed, rather than being made available to GPs in search of a contract. Posts are suppressed where the HSE (following consultation with the IMO) believes that the patients of a deceased or retiring contract-holder can be adequately catered for by the existing GP(s) in an area. This typically arises where the patient list involved is so small that it is thought unlikely to be able to support a viable practice. In these circumstances, the patient list will be taken over by a GP already *in situ*, or divided out among the existing GPs in the area.

Location-specific contracts

The GMS system effectively seeks to divide up the market for public patients between participating GPs through the allocation of patient lists in specific locations throughout the State.

GPs applying for a contract under the GMS are not simply applying for the right to treat public patients; they typically apply for a list of patients in a particular location.[19]

[18] Department of Health and Children, Circular on Entry to the GMS, Circular 3/96, 19 June 1996.

The GMS system encourages GPs to locate 'where the lists are' rather than where they see a business opportunity. This leads to inertia, sluggish responses to changing demographics, and a reduction in competition. In theory, new posts will be created for areas which are experiencing rapid population growth. In practice, however, the system actively curtails the creation of new practices, and favours working through existing practices wherever possible.

IMO involvement

The IMO is centrally involved in all stages of the process governing the number, location and allocation of GMS contracts. The IMO is consulted on all decisions regarding the creation or suppression of GMS posts and a nominee of the IMO sits on the interview panel for all GMS positions.

IMO role in fee-setting

The GMS contract provides for changes in the fees paid to GPs under the GMS to be made by agreement between the Minister for Health and Children and the IMO.

Collective negotiations by "undertakings"[20] on fees are prohibited by Section 4 of the Competition Act 2002 ("the Act") and by Article 101 of the Treaty on the Functioning of the European Union. (It is the opinion of the Competition Authority, on the basis of legal advice, that GPs contracted to provide services to public patients under the terms of the GMS are "undertakings" for the purposes of the Act and thus fall within the remit of the Act.)

The reason for the prohibition on collective negotiation by undertakings is to protect consumers and the State from concerted practices by independent businesses which could result in them (i.e. consumers and/or the State) paying higher prices than they would otherwise have to. In the current instance, the prohibition is intended to protect the State from paying excess prices for GP services purchased by the HSE.

The principles at stake here are important and go to the heart of competition policy:

- Competition law protects consumers (and businesses) from collective action designed to force another party to negotiate with them.

[19] On occasion, contracts are offered without a patient list.
[20] An "undertaking" are defined in section 3 of the Act as meaning *"a person being an individual, a body corporate or an unincorporated body of persons engaged for gain in the supply of goods or the provision of a service".*

- This same protection exists for the Exchequer. For example, in 2009, the Government decided to reduce the fees paid to pharmacies for dispensing drugs under the community drugs schemes. It was aided in doing so by the protections of competition law. Pharmacists held a campaign of sustained pressure in an effort to force the Minister for Health and Children to reconsider the new prices. The Minister refused, supported by competition law which prohibited pharmacies from collectively negotiating their fees. Competition law thus helped protect the State and Exchequer from what might otherwise have been a successful attempt to resist fee reductions by pharmacists.

A recent judgement of the Irish High Court sets out an approach to fee-setting ("the Hickey approach") which has been approved by the courts and which does not conflict with competition law.[21] We have recommended that this type of approach be adopted in any future changes to the GMS fees.

This approach allows the State to consult with representative bodies and/or their members on the fee structures for various State-operated schemes. Ultimately, the State unilaterally decides on a fee that it is willing to pay for the services provided. The Competition Authority has published guidance on similar models that enable health professionals providing services to the State to engage with the State on the matter of fees, while maintaining compliance with competition law.[22]

Findings of the Competition Authority

The GMS system favours existing GP practices and protects them from competition from newly-qualified GPs. Established GP practices are protected by:

- **Barriers to entry** which restrict access to GMS contracts and make it difficult for newly-qualified GPs to set up in competition with existing practices;

- The **"viability criterion"** used to determine the creation or suppression of GMS posts; and

- The **marking system** used at GMS interviews, which favours GPs who already hold GMS contracts.

[21] *Hickey and others v HSE [2007]*, judgement of 11 September 2008.
[22] Competition Authority *Notice in Respect of Collective Action in the Community Pharmacy Sector*, Decision No. N/09/001, 23rd September 2009.

The restrictions on competition arising out of the GMS system affect both private patients and public patients:

- Both public and private patients have fewer GP practices to choose from.
- There is less pressure on GP practices to compete on price for private patients and to be innovative in the service they provide.

The impact of the GMS on private patients in Ireland is often overlooked. It is assumed that "the market" will take care of them. This ignores the fact that the market for private patients is itself significantly affected by the operation of the GMS. The GMS system impacts directly on the commercial behaviour of almost every GP practice in the State, affecting decisions on where GPs locate, the number of GP practices established, the nature of such practices and the profitability of individual practices. This, in turn, affects the provision of services for private patients and indirectly influences the price GPs charge private patients.

The restrictions on competition resulting from the GMS system also adversely affect many GPs. This is particularly obvious in the case of newly-qualified GPs who are trying to set up in practice, but also applies to existing doctors, many of whom are overworked and unable to accommodate additional patients.[23]

Recommendations for change

We have recommended a series of changes which will, if implemented, result in opening-up the system of awarding State contracts to GPs in Ireland and facilitate increased competition between GPs with consequent benefits for patients – and indeed for many doctors too.

Our recommendations fall into two categories:

A. The removal of practices which protect established GMS-contracted GP practices from competition from newly-qualified GPs.

Recommendation 1: Access to GMS Contracts should be opened up to all qualified and vocationally trained GPs, who meet general suitability criteria.

[23] A nationwide survey of GPs carried out by the IMO in 2009 found that one-in-three GPs limit patient registration due to an excessive workload. 44% of GPs found that there were not enough GPs to meet the needs of the area, particularly in the Dublin area. IMO Survey 2009 (unpublished).

Recommendation 2: GPs in possession of a GMS contract should be free to set up in, or move to, the location of their choice.
Recommendation 3: Decisions to award a GMS contract in a particular area should not be required to take account of the "viability" of existing GP practices in that area.
Recommendation 4: The marking system for awarding GMS contracts should be amended to ensure that applicants with similar levels of GP experience are awarded equal points and that applicants already in possession of a GMS contract are not treated more favourably.

B. Changes in the process for determining payments to GPs under the GMS.

Recommendation 5: Payments to GPs under the GMS should be decided, not on the basis of agreement with the IMO, but unilaterally by the Minister for Health and Children, following (if desired) consultation with GPs and/or the IMO.

Initial reaction to our proposals

The initial response to our proposals has been along predictable lines:

- Younger GPs, and indeed some established GPs, have reacted positively to our recommendations, welcoming the suggestion that access to State contracts be opened up.[24]
- The HSE and the IMO have given a qualified welcome to our proposals, acknowledging the need for change in the system while suggesting that some limits should be placed on these reforms.
- The Minister for Health and Children has already publicly indicated that she welcomes our proposals.

[24] See, for example, Irish Examiner, 14 July 2010, *Young doctors shut out of medical card system.*

The challenge now will be to move forward from that broad level of support to develop a clear programme of implementation.

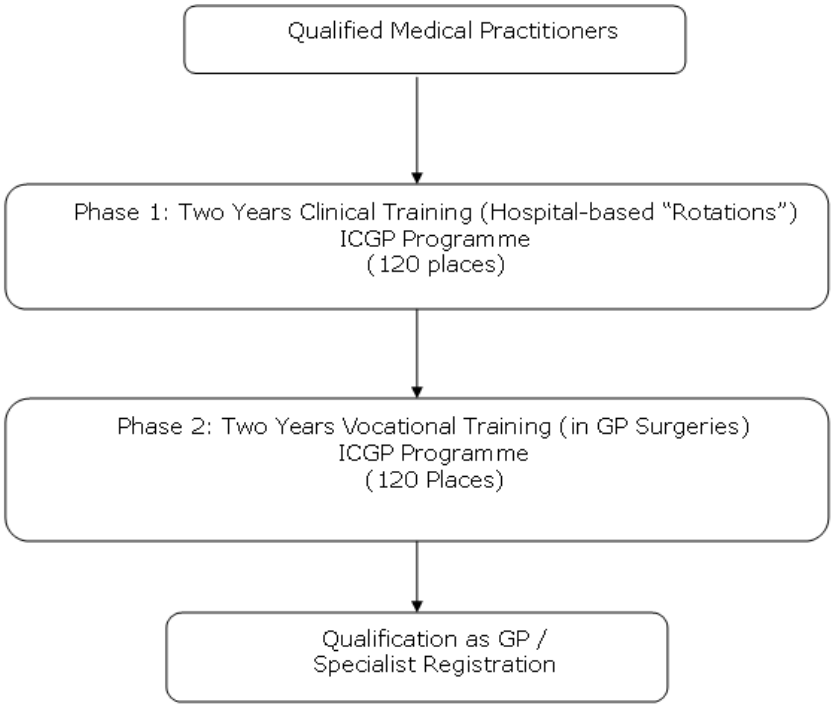
Problem Area 2: Access to GP training programmes

The second problem area we identified relates to restrictions on access to GP training programmes – in particular, the failure to recognise the relevant prior learning and experience of many applicants for GP training programmes, which forces them to repeat training already completed.

How to qualify as a GP in Ireland

In order to qualify as a GP in Ireland, students must first complete a five or six-year undergraduate medical course and then complete a four-year specialist programme in general practice (see Figure 2).

Figure 2: GP Training in Ireland: Current Model



The crucial step for an aspiring GP wishing to train in Ireland is to gain a place on an ICGP-accredited GP training programme. The ICGP is the sole body recognised by the Irish Medical Council for the accreditation of specialist training in general practice in Ireland.

ICGP training comprises two phases:

- Phase 1: two years of hospital-based training comprising four six-month "rotations" in areas of medicine relevant to General Practice, such as Paediatrics, Psychiatry, General Medicine, and A&E. Trainees attend a half-day workshop each week aimed at increasing their understanding of medicine outside the hospital setting; and
- Phase 2: two years working under supervision as a trainee in a GP practice. This includes weekly full-day workshops outside of the medical practice.

Post-graduate specialist GP training is "on the job". Trainee GPs actively provide services to patients under the supervision of a consultant (within a hospital) or a trainer GP (in a GP practice), and receive a salary from the HSE during both phases of their training.

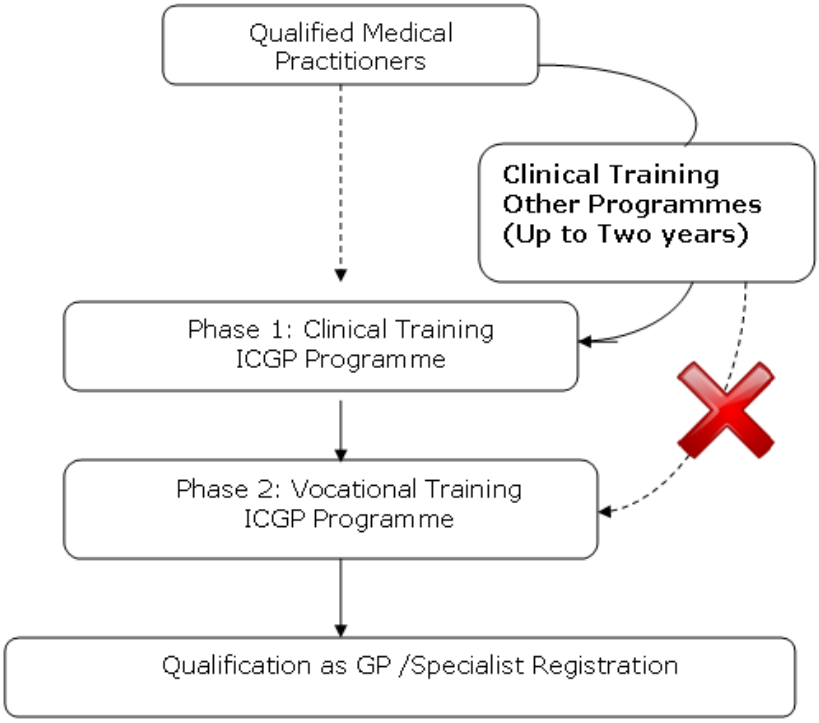
Demand for places on ICGP training programmes far exceeds the number of places available. In 2009 there were 360 applications received for 120 places.

Junior doctors who fail to get on an ICGP training programme at their first attempt may re-apply to the ICGP in subsequent years. They may in the interim take up posts as junior hospital doctors which are designated as training posts. This is known as "self-structured training". Alternatively, a junior doctor accepted for training in another specialty programme may subsequently change their mind and wish to switch to General Practice.

The problem with the current model

Doctors who do not follow the direct route to becoming a GP, and who pursue alternative clinical training in the interim, have to start their post-graduate training again if they are subsequently accepted onto an ICGP training programme. Hospital-based experience gained while working in approved training hospitals, in positions equivalent to those held by GP trainees, is not recognised. Instead, the ICGP treats all new entrants into ICGP programmes as if they had entered the course immediately after qualifying as a medical practitioner (see Figure 3).

Figure 3: Current Model of GP Training: Non-Recognition of Relevant Clinical Training.



Effect of the Restraint

The requirement to repeat training already completed extends the length of training for those doctors affected by the restriction (i.e. those switching from self-structured training or from another specialty training programme). This in turn delays and limits the number of new GPs available to treat patients in Ireland.

The failure to recognise relevant prior clinical training is costly to taxpayers (who must pay for doctors to repeat their training) and inefficient (in that it slows down the growth in the supply of GPs at a time when the demand for GPs is rising).

Recommendation for change

We have recommended the introduction of a new fast-track GP training course for doctors who have already acquired relevant hospital training and experience. Suitable applicants would be able to proceed immediately to the final two years of the GP training programme, subject only to completing a short general practice orientation programme. This would enable more GPs to be trained as quickly and

as cost-effectively as possible, while eliminating unnecessary duplication of training.

Reaction to our proposals

The Irish College of General Practitioners has agreed in principle with our proposals. The number of training places on GP training programmes was increased this year from 120 to 157. However, none of the additional places was allocated to our proposed "fast-track" entrants. We are continuing to advocate the benefits of reform in this area.

Problem area 3: Advertising by GPs

The final area where we identified restrictions on competition relates to advertising by GPs.

Advertising traditionally severely restricted

Until very recently, GPs in Ireland were very restricted in their ability to advertise their services. Doctors setting up in practice could only announce their presence by way of a small newspaper notice. Local radio announcements, flyers and other normal methods of creating awareness of a new business were not allowed. Advertising of prices was actively discouraged. These restrictions were set down and enforced by the statutory regulator – the Irish Medical Council.

Restrictions on advertising by GPs rescinded in 2009

Following detailed submissions from the Competition Authority, the Medical Council amended their guidelines on advertising. The guidelines now explicitly recognise that:

> "*The provision of information about the availability of medical services through the media, internet or other means is generally in the public interest provided that the information is factually accurate, evidence-based and not misleading*."(emphasis added)[25]

This is a significant change in tone, and indeed content, from the previous guidelines.

[25] "*A Guide to Professional Conduct and Ethic for Registered Medical Practitioners*" (7th Edition), Medical Council 2009 page 49.

The guidelines go on to say that medical practitioners may advertise their practice by "*publicising the name and address of the practice, the practice hours and contact details*". Doctors may also include their area of speciality.

The provision of information beyond this fairly minimal level is permitted, providing "*the information published in the advertisement is true, verifiable, does not make false claims or have the potential to raise unrealistic expectations*".

This means that GPs are now free to advertise the services they provide, and their prices, if they so choose.

Benefits

The new Medical Council guidelines should make it easier for consumers to obtain information on the availability and price of medical services in their area. This may lead to more competitive pricing for private patients, if consumers are in a better position to shop around.

There is anecdotal evidence that some GPs are starting to advertise their services. The ability to advertise is particularly important to newly establishing GPs who need to let patients know of their existence. More GPs are due to come on stream in the next few years.[26] If access to State contracts to treat public patients is opened up, as we recommended, more of these newly-qualified GP may set up in practice. These GPs will benefit from being able to advertise their services.

The benefits of the new guidelines are likely to be felt over time, as GPs become more aware of their right to advertise and patients push for more information on prices. In recent months, there has been an extensive media campaign in Ireland calling for more transparency on GP prices. This campaign would have been inconceivable even twelve months ago.

Concluding comments

To return to the opening theme of this paper, there will always be a constant struggle of ideas on the extent to which we can apply competition principles to healthcare.

[26] The intake to GP training programmes was increased in 2010 and further increases may occur in future years as the number of doctors graduating from Irish medical colleges rises.

A recent OECD Study put this very well –

> *"The issue for policy makers … is not whether markets are good or bad, but … whether fostering some aspects of competition and markets in the health sector can lead to more rational use of resources, and which aspects of competition have the greatest potential to get results."*[27]

[27] *Achieving Better Value for Money in Health Care*, OECD Health Policy Studies, November 2009