Irish College of General Practitioners

Pre-budget Submission 2017

September 2016

Contents

Introduction

- In this year's pre-budget submission, the Irish College of General Practitioners (ICGP) has outlined fourteen key recommendations, which are central to the creation of a sustainable, cost-effective healthcare service. There is unequivocal evidence that a well-resourced, general practice-led, primary care system is capable of a) managing patients with multiple chronic illnesses (multimorbidity) and b) curtailing overall healthcare costs.

- The typical patient in Irish general practice suffers from many chronic illnesses. We describe the experience of one patient to illustrate why our key recommendations are necessary.

- The attached appendices provide detailed insight for each of our fourteen recommendations. Together with the implementation of a new GP contract as an overarching priority, we offer sustainable cost-effective solutions to rising healthcare demand.

Key Recommendations

1. New GP Contract:
   ICGP recommends the introduction of a new contract for general practice as an overarching priority, including provision for its review and development as an on-going process, between the Department of Health and GPs. The current capitation-based, GP contract was established in 1989 and does not provide for the care of persons with chronic illnesses.

2. Community-based chronic illnesses management:
   A comprehensive community-based chronic disease management programme, encompassing the management of patients with multimorbidity, will reduce healthcare costs and improve patient outcomes. Crucially it will reduce OPD attendances, reduce Emergency Department visits and increase bed occupancy, enabling hospitals to focus on secondary care and facilitating necessary capacity for the creation of a single-tier universal healthcare system. General Practice should have a central, enhanced role in Integrated Care Programs and Clinical Care Programs.

3. Funding general practice:
   ICGP recommends resourcing Irish general practice in line with OECD countries, given historic underfunding and more recent reductions through FEMPI. Irish general practice receives 2-3% of public health expenditure, which compares to 11% in the UK.

4. Increasing capacity in general practice and primary care:
   ICGP can work with government to urgently address manpower shortages in general practice and primary care. ICGP can increase GP training capacity annually with adequate resources. However, training GPs, only to see them emigrate to other health systems, is not cost-effective. Recruitment and retention of GPs begins with the provision of an adequately resourced general practice system. Increasing the present number of GPs will require significant investment in general practice to retain our younger GPs and recruit those who have emigrated abroad. ICGP can also collaborate with nursing training bodies enabling the parallel training of necessary additional Practice Nurses.

5. ICT capacity and monitoring performance:
   ICGP recommends negotiation with GPs of an anonymised aggregated data extraction system, enabling real time data collection for purposes of service development and safety. We recommend the urgent provision of primary care based integrated national electronic health records, using a unique patient identifier. Failure of secondary care to computerise is an outstanding weakness in the Irish health system.

6. Expanding built capacity / infrastructure in existing general practices:
   To build general practice capacity, ICGP recommends the negotiation, with GPs, of an agreed mechanism to expand built capacity in existing practices. Development of General Practice and Primary Care Teams (PCTs) must be prioritised. Success can be ensured through; a) Liaison with GP representative bodies - as different solutions will be required in different

communities; and b) Pragmatic research on PCTs considered successful by their participants and dissemination of best practice.

7. Medications management:
   ICGP recommends inclusion of a medications management programme in the GP contract, enabling safer prescribing and cost savings for the State and individual patients. ICGP can put in place the educational element of this, collaborating with RCPI and The National Pharmacoeconomics Centre.

8. Building access to diagnostic services:
   Patients are unable to access necessary diagnostics. ICGP recommends immediate expansion of radiological, cardiac and endoscopic investigations for all patients. Diagnostic facilities need to be considered separate to hospitals. We recommend a uniform national standard waiting time for key investigations based upon reasonable international standards.

9. Building access to primary care and mental health services:
   ICGP recommends expansion of allied primary care professionals, including psychologists, community psychiatric nurses, and occupational therapists in primary care, with improved nursing capacity in communities (Nurses / Health Assistants / Carers). GPs manage the majority of mental health complaints in the Irish State, such as addiction, anxiety and depression. A severe shortage of primary care psychological services in particular is curtailing effective management of these mental health conditions.

10. Universal primary healthcare:
    ICGP supports increasing access to general practice and primary care, contingent on building capacity in personnel, IT infrastructure and built infrastructure in existing premises. Expanding access through means testing is the fairest mechanism.

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

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

13. Public health and health promotion:
    ICGP recommends a government-wide approach on obesity, sedentary lifestyle, problem alcohol use, stress and tobacco. GPs and general practice teams are well placed to address

health promotion with patients, given adequate expansion of capacity. Simple distribution of resources based on populations or geography is flawed, and distribution should reflect the needs of remote and deprived communities.

14. Reversal of fragmented care:

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

Context of pre-budget submission

General practice is the key to sustainable healthcare

- It is recognised since the Alma Ata declaration, that strengthening primary care provides the greatest benefit for health systems and populations over time [1].

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

Why is general practice effective?

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

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

[1] WHO. Declaration of Alma- Ata. 1978.
[2] Starfield B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report. 2012.
[3] Starfield B, et al. Contribution of Primary Care to Health Systems and Health, The Millbank Quarterly. 2005.
[4] Moynihan R. Preventing overdiagnosis: how to stop harming the healthy. BMJ. 2012.
[5] RCGP. Promoting continuity of care in general practice. 2011.

2. Coordination of care:
    - Excessive outpatient (OPD) appointments in the healthcare system cause confusion, poor concordance with treatments, duplication of testing, and care which is essentially ungovernable and stressful for patients.
    - GPs coordinate complex care needs of patients, helping patients navigate a system, which often feels difficult and fragmented.
    - Coordination of care across providers and settings is felt to be essential to chronic disease management in particular [6]. The GP performs a *generalist* role, unique among doctors, combining diagnostic and management skills which ignore the boundaries of specialty practice [7]. This allows the GP to integrate the broad scope of general practice with the individual circumstances of the patient (and their family) and guide the patient through the often fragmented world of healthcare [8].

3. First contact for patients in the healthcare system:
    - GPs are gatekeepers, controlling entry to the secondary system (except in emergency situations) [9].
    - Costs escalate if GPs are not enabled to gatekeep appropriately.

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

Chronic illnesses and multimorbidity

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

- Chronic illnesses include coronary heart disease, chronic obstructive pulmonary disease, arthritis, mental health conditions, the dementias, and major cancers.
    - Chronic illnesses should be managed with community services, led by GPs; this is a key but yet unrealised policy objective of successive governments [12].
    - The GP contract precludes GPs managing chronic illnesses (diabetes excepted).

[6] Rothman AA et al. Chronic illness management: What is the role of primary care. Ann Int Med. 2003
[7] McKee et al. Responding to the challenge of chronic disease: ideas from Europe. Clinical Medicine. 2004
[8] Philips W et al. The Domain of Family Practice: Scope, Role and Function. Family Medicine. 2001.
[9] Forrest C. Primary care gatekeeping and referrals: effective filter or failed experiment? BMJ. 2003.
[10] Gouda P et al. Treat or refer: Factors effecting GP decisions. Forum. 2013.
[11] IMO. Solving the Chronic Disease Problem though General Practice. 2016.
[12] Department of Health. Tackling Chronic Disease. A Policy Framework for the Management of Chronic Diseases. 2008.

- Chronic illnesses are now managed inadequately in outpatient hospital settings, despite overwhelming evidence this is sub-optimal and that GPs and practice nurses are willing to take this work on [13].
- The present system is ruinously expensive. Each individual outpatient visit in an Irish public hospital costs ~ €167 per annum. The cost for a GMS patient in general practice for one whole year is €116 [14]. This out-dated model overwhelms public outpatient waiting lists and exacerbates ED visitation rates.

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

[13] Darker C et al. Chronic Disease Management in Ireland. Perspectives from Patients and Clinical Stakeholders- implictions and recommendations for the Irish healthcare system. 2015.
[14] PCRS. Statistical analysis of claims and payments 2014.
[15] Barnett K et al. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet. 2012.

The view from general practice

A typical day in general practice:

- GPs consult with over thirty-five patients per day.
- GPs would also attend house calls and nursing home visits.
- Each consultation generates three problems, two brought by the patient and one identified by the GP [16]. Patients are effectively managed in general practice with onward referral in less than 1:10 cases [17].
- GPs manage growing volumes of administration from a range of agencies.
- GPs review and sign 15-30 repeat prescriptions, most with multiple items.
- Practice Nurses see similar numbers of patients, performing phlebotomy (taking blood), cervical smears, dressings, triaging urgent cases and immunising children, all working under GP supervision.
- GP and Practice Nurses contact many patients daily (or families, nursing homes or hospitals) to give results or answer queries (by text/ phone/ email).

A typical patient in general practice:

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

Case study:

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

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

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

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

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

[16] Salisbury C et al. The content of general practice consultations: cross-sectional study based on video recordings. BJGP. 2013.
[17] Gouda P et al. Treat or refer: Factors effecting GP decisions. Forum. 2013.

d) Mary suffers from significant **mental health difficulties:**

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

Medications:

- Mary takes thirteen regular long-term medications, requiring regular monitoring and review by her GP.
  - Aspirin (for heart disease)
  - Atorvastatin (for heart disease)
  - Ramipril (for high blood pressure, diabetes and heart disease)
  - Bendroflumethiazide (for high blood pressure)
  - Bisoprolol (for high blood pressure and heart disease)
  - Warfarin (for atrial fibrillation)
  - Metformin (for diabetes)
  - Gliclazide (for diabetes)
  - Buprenorphine patch (an opiate patch medication, for pain)
  - Paracetamol (for pain)
  - Topical anti-inflammatory (for pain)
  - Thyroid hormone (for underactive thyroid)
  - Inhalers X 2 (for chronic obstructive pulmonary disease)

Healthcare utilisation:

a. General practice:
   - She attends her GP approximately **ten times per year**, usually for infective exacerbations of her bronchitis, for pain, and mental health difficulties.
   - With her GP emigrating recently and rising waiting lists, it now takes over one week to make an appointment to see a GP.

b. Hospitals:
   - Outpatients:
     - She had 21 appointments at two local hospitals in 2015 – she frequently misses appointments.
     - She attends nine outpatient services (between two different hospitals), including cardiology, diabetes, orthopaedic, and respiratory OPDs.
     - She required twelve blood tests each year for warfarin alone.
     - Public OPD clinics (often run by Junior Hospital Doctors) order X-rays and bloods, frequently duplicating tests, which is very frustrating for Mary.
     - She often misses hospital clinics, citing the cost of a taxi and seeing "a different doctor every time". She has missed her diabetes and respiratory appointments the last two years.
   - Emergency Department:
     - She attended the local Emergency Department twice this year with infective exacerbations of her chronic obstructive pulmonary disease, being unable to obtain timely appointments with her GP (estimated cost of unscheduled ED admissions is estimated at £3,200 per admission in the NHS).

Appendix 1: Challenges for a sustainable healthcare service

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

1. New GP Contract

- The current capitation-based, GP contract was established in 1989 and does not provide for the care of persons with chronic illnesses.
- ICGP recommends the introduction of a new contract for general practice as an overarching priority, including provision for its review and development as an on-going process, between the Department of Health and GPs.

2. Chronic illness management

- Chronic illnesses are poorly managed in Ireland, with excessive costs from hospital outpatient visits, increases in waiting lists, rising ED visits (from uncontrolled chronic illnesses), worse outcomes for patients and poor medication management [18].
- In the case study above:
    - Mrs Smyth is unable to have her chronic illnesses managed by her GP, as there is no provision in the GP contract, excepting Diabetes.
    - Mary attends two different hospitals for nine annual outpatient appointments, and also attends hospital on twelve occasions for blood tests. All of these visits could take place in general practice.
    - Mary misses hospital-based appointments. She cannot afford a taxi, is chronically unwell and depressed.
    - Mary's chronic illnesses are not well controlled (such as her chronic obstructive pulmonary disease), and as a result she gets exacerbations of her illness, and attends the Emergency Department.
- It is internationally recommended that chronic illnesses should be managed in general practice through structured chronic disease management programmes [19].
- Recent evidence states that patients with multiple chronic illnesses receive conflicting advice, duplicated investigations and unnecessary medications when single disease guidelines are applied to their care. There should be a focus on the management of multimorbidity, rather than single disease protocols, as part of chronic disease management.
- Mary's nine hospital outpatient visits and multiple phlebotomy appointments could be incorporated into a GP led chronic disease management programme. Visits could be consolidated and reduced in a generalist service, allowing Mrs Smyth to be treated closer to home, in a patient-centred manner. Managing patients with multiple chronic

[18] Starfield B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report. 2012.
[19] RCGP. Health Select Committee Inquiry on Management of Long-Term Conditions. Available from http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Written-Evidence-Long-Term-Conditions.ashx

conditions (multimorbidity) in a person-centred manner can be facilitated in general practice, in accordance with best evidence [20].

- ICGP has repeatedly demonstrated GP-delivered peer-reviewed clinical evidence to support the requirement for the Government, DoH and HSE, to properly focus on the prioritisation of primary care and General Practice as the solution to Ireland's problems in dealing with Chronic Disease Management (e.g. Heartwatch[21]). Up to 2014, ICGP was engaged with the HSE Clinical Care Programmes, and developed models of care and guidelines to support Ireland's main chronic diseases (Diabetes, Heart Failure/ CAD, COPD, Asthma and Mental Health).
- In particular, most mental health conditions are treated within the general practice setting. Addiction, anxiety, depression and stress can all be effectively managed, with supports from primary care colleagues, and occasionally our colleagues in secondary care.
- ICGP welcomes the introduction of a Diabetes Cycle of Care in October 2015, as a first step towards moving chronic disease management to the community.
- The stumbling block for roll out of these clinical models is the underfunding of primary care infrastructure. ICGP supports developing integrated care programs, particularly with the appointment of a GP as National Primary Care Lead. To ensure the success of general practice-based chronic disease management programs, GPs will need to have an enhanced, central role in future Clinical Care Programmes.
- High quality training, research and continuous medical education (CME) enable continuous quality improvement in the health sector.
    - CME for GPs and Practice Nurses needs to be enhanced to meet future healthcare and regulatory requirements. This is best achieved by a collaborative approach between ICGP and Government.
    - Research is essential for health system development, enabling analysis of workforce planning, enhancing quality and safety, researching prescribing and patient outcomes. Enhanced government funding of primary care research, with structured career pathways for GPs, Nurses and other primary care professionals wishing to pursue academic interests, would deliver value for the investment.
- ICGP supports advancement of the role of GPs with special interests, aligning themselves to agreed areas of priority (e.g. clinical programmes, minor surgery and minor injury programmes).

Solution(s):

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

[20] Wallace E et al. Managing patients with multimorbidity in primary care. BMJ. 2015.
[21] O'Riordan M. Chronic disease care- redressing the balance. Forum. March, 2015.

3. Funding deficits in Irish general practice

- **Irish general practice is under-funded** compared with OECD nations.
- **Government spends just over 2-3% of the health budget in general practice, compared to 11% in the UK [22].**
- The 'business model' of modern Irish general practice is becoming increasingly dysfunctional.
- FEMPI legislation has removed over 30% of government income for GMS services, which is crippling general practice, limiting the care patients receive and adding to difficulties in retaining GPs.
- A sustainable healthcare service needs to invest in general practice.

Solution(s):

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

4. Personnel capacity: GP and Practice Nurse capacity in Irish general practice

- Ireland has low numbers of GPs per head of population in the OECD [23]. The aging GP workforce, low numbers of postgraduate training places for GPs, and failure of retention of young GPs all contribute. Failure of retention is driven by aggressive recruitment of Irish GPs internationally, an out-dated and inflexible GP contract, and the realisation that inequity and inefficiency in the present Irish health system are incompatible with the practice of good medicine. Further, established GPs are now beginning to leave mid career [24].
- **GP training:**
  - ICGP embraces the transfer of GP training to the ICGP (HSE SLA with ICGP).
  - ICGP recommends increasing capacity of the National GP Training Programme during the next 3-5 years.
  - ICGP recommends development of multidisciplinary postgraduate training of specialist GP Trainees, Nursing graduates and Practice Administrators.
- **Recruitment and retention:**
  - Training GPs, only to see them emigrate to other health systems, is not cost effective. Failing to retain our GPs will erode and prevent the creation of a sustainable primary care-based healthcare system in the future. Recruitment and retention of GPs begins with the provision of an adequately resourced general practice system. Many younger GPs emigrate to work in healthcare systems where there are comprehensive chronic disease management programs and there are no delays accessing diagnostics. Engaging with emigrated and emigrating GPs and evaluating their reasons to stay/ return must be a priority of government.

[22] ICGP. Pre-Budget submission 2015. Available from http://www.icgp.ie/go/library/catalogue/item?spId=5F92634A-B5A0-F573-848D76D9F4D72662
[23] Oireachtas Library and Research Service. GPs and the Irish primary care system: towards Universal Primary Care? No. 1. 2014.
[24] O'Kelly M et al. ICGP. Structure of General Practice 1982 – 2015. 2016.

- ICGP published a report in 2015 highlighting that only one third of current GP trainees are confident enough in their futures in the Irish health system to consider planning on staying in Ireland [25]. Viability of general practice in Ireland (20%) and financial prospects (36%) are main reasons cited for leaving.

- Areas of deprivation:
  - The case of Mrs Smyth highlights what is happening in areas of deprivation. It is a direct example of Julian Tudor Hart's Inverse Care Law. *"The availability of good medical care tends to vary inversely with the need for it in the population served. This ... operates more completely where medical care is most exposed to market forces."* [26]. Evidence highlights the association between socio-economic deprivation and poor health. One in four practices in Ireland are in deprived communities.
  - Practices in deprived communities have differing financial, personal, professional and educational needs. A fundamental solution to present health inequalities, glaringly evident in deprived communities, is strong, well-resourced general practice / primary care.
  - It is difficult to recruit new GPs to work in areas of deprivation. At present, it remains financially penalising and professionally challenging. Deprived areas have fewer GPs making it more difficult for patients to access services. Nationally there is one GP per 1600 of population (less than the OECD norm). In North Dublin there is one GP per 2500 population.
- Rural general practice:
  - A second 2015 ICGP Report ("*A vision for the future of Rural General Practice*") highlighted challenges facing rural general practice. Rural GMS lists remain vacant. Substantial cuts in top line payments (FEMPI) and discontinuation of rural distance codes have rendered rural practice non viable at present.
  - The Rural Practice Allowance (RPA) is an essential support for rural general practice and restoration of this allowance is welcome as a first step.
  - We recommend additional financial, educational and professional supports, highlighted in this ICGP report [27].
- Out of hours:
  - Out of Hours (OOH) services are under pressure to maintain care with rising attendances in recent years, exacerbated by introduction of the Under 6 contract.
  - We recognise the potential of GP Co-operatives and recommend they are supported in expanding roles in minor injuries management, co-ordinating care with CITs, augmenting primary palliative care and supporting day time general practice with overflow clinics, locum placements and complaints management. All of these additional elements are underway in individual co-operatives, and directly assist in addressing pressing issues in both general practice, and the health system. These activities enable more care in the community, at reduced cost, with higher patient acceptability.
- Practice Nurses:

[25] ICGP. Bridging the Gap- How do GP Trainees and Recent Graduates identify themselves as the future of Irish GP Workforce. 2015
[26] Tudor Hart J. The Inverse Care Law. Lancet. 1
[27] ICGP. A vision for the future of Rural General Practice. 2015.

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

Solution(s):

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

5. ICT capacity and monitoring of performance

- National GP dataset/ IPCRN/ Monitoring quality:
  - Chronic disease programmes require assessment of efficacy. Given the structure of GP electronic medical records systems, this is set up but not utilised in the Irish system. We recommend the usage of anonymised aggregated datasets (agreed by GP representative bodies). This involves real time capturing, monitoring and feedback to guide performance and development. The Irish Primary Care Research Network (www.ipcrn.ie) has been developed as a real time method of data analysis based on use of agreed coding. IPCRN involves collaboration between ICGP and academic partners (NUIG, AUDGPI, HRB Centre for Primary Care Research (RCSI)). This collaboration can now easily deliver, with the HSE, a high quality evolving real time dataset, based on detailed activities of GPs, Practice Nurses and Practice Administrators.
- Integrated health records:
  - ICGP recommends each individual has a single electronic medical record, accessible to them, held and managed by their nominated GP, shared by their GP with allied agencies, as required.
  - ICGP recommends all health professionals maintain clinical notes on electronic records.
  - The costs of implementing new IT infrastructure, and on-going maintenance, will need to be adequately resourced by government, in agreement with GP representative bodies. ICGP recommends the continued involvement of the GPIT group, with the HSE and DoH, in national IT projects and eHealth Ireland, to ensure integration of health records.

Solution(s):

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

6. Built capacity

- There are over 25 million GP consultations per annum in Ireland [28]. This will increase given expansion of GP/ Practice Nurse activities from chronic illness management, and increasing access provided by expanding PCRS eligibility.
- Physical capacity of GP surgeries to address workload requires to be expanded.
- Government and GP organisations must collaborate to ensure resources and arrangements to enable augmentation of GP capacity grow in line with patient need.
- ICGP supports GP involvement in primary care teams (PCTs) [29]. PCTs do not need to be geographically co-located. Constructing primary care centres without involvement of local GPs does not mean a PCT care team is functional. It is a top-down approach to policy implementation, which at present only appears to work sporadically [30].

Solution(s):

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

7. Medications management

- The cost of the community drugs bill was €1.1 billion, including payments to pharmacists, in 2014. As an example this compares to the overall GMS payment to GPs in 2014 which was €428 million [31] (proportionally five times less than the UK).
- For patients like Mrs Smyth, biannual reviews by GPs of medications are recommended [32]. ICGP recommends Government liaise with GP organisations to establish medication review structures as integral to the GP contract.

Solution(s):

- ICGP recommends immediate development of a medications management element in the GP contract, enabling safer prescribing and savings, based on an expanded Preferred Medicines Scheme, coordinating with Integrated Care

[28] Behan W et al. Are Irish Adult General Practice Consultation Rates as Low as Official Records Suggest? A Cross Sectional Study at Six General Practices. IMJ. 2013
[29] ICGP. Primary Care Teams. A GP perspective. Forum. 2011. Accessed at http://www.icgp.ie/go/library/catalogue/item?spId=2E2053C3-2415-497E-AA0CF5883AFEC988
[30] http://www.irishtimes.com/news/health/delays-to-35-out-of-36-planned-primary-care-centres-1.2741670
[31] PCRS. Statistical analysis of claims and payments 2014.
[32] Wallace E et al. Managing patients with multimorbidity in primary care. BMJ. 2015.

Programmes and the National Pharmacoeconomics Centre

8. Building access to diagnostic services

- GPs are unable to access radiological, cardiac and endoscopy investigations for non-private patients.
- For radiological (e.g. CT and MRI) and cardiac (e.g. echocardiography) investigations, GPs do not have effective access for public patients. GPs must therefore refer patients to Outpatient Departments or Emergency Departments. This is wasteful of OPDs, EDs, compounds delays and represents a clear level of medical risk for public patients in delayed diagnoses.
- The 2016 ICGP report '*Access to Diagnostics Used to Detect Cancer*' highlights the lack of access to tests for cancers, which can lead to delays in diagnosis, predominantly for public patients. Delayed diagnoses lead to worse outcomes for public patients, increasing costs, with need for more invasive / expensive treatment, of more advanced disease [33]. A recent UK study demonstrates this regarding comparative costs of treating Stage 1 Vs. Stage 4 colorectal carcinoma.
- A uniform national standard waiting time for key investigations needs to be implemented against which services can be benchmarked, based not on incremental improvement on historic performance, but on neighbouring health systems. For example

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

Solution(s):

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

9. Building access to primary care services

- Primary care staff: GPs experience difficulties for both GMS and private patients, relating to referral to primary care services. For GMS patients, there can be inordinate delays in referrals to certain services (e.g. long waiting lists for physiotherapy), resulting in clinical deterioration, and in requirement to refer to OPD. Many non-GMS patients have no

[33] Incisive Health and Cancer Research UK. Saving lives, averting costs. Analaysis of the financial implications of achieving earlier diagnosis of colorectal, lung and ovarian cancer. 2014.

access to public primary care services and must pay the full costs of seeking primary healthcare (e.g. attending a private physiotherapist).

- Primary care teams: GPs must be enabled to attend multidisciplinary meetings. Currently, this is largely impossible, and the inability of GPs to engage meaningfully with primary care teams is a major block to efficient and effective care.
- GPs manage the majority of **mental health** complaints in the Irish State (addiction, anxiety, depression). A severe shortage of primary care psychological services in particular is curtailing effective management of mental health conditions.

Solution(s):

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

10. Unfair access to secondary care

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

Solution(s):

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

11. Universal healthcare and funding models

- Effective universal healthcare systems are underpinned by strong primary care, centred on effective and resourced general practice. Urgent investment in general practice and primary care is required to enable the introduction of a single-tier system.

a) Universal secondary healthcare:

- ICGP supports universal healthcare with single waiting lists for secondary care.
- Three funding options are available to create such a system:
    a) Tax-funded, publicly delivered single-tier system
    b) Single payer model/ single-fund insurance (single-tier) system
    c) Universal health insurance (single-tier) system, with competing insurers
- ICGP is well placed to assist in evaluating proposals for system reform.

b) Universal primary care:

- ICGP supports primary care and general practice free at point of contact.
- Most OECD countries have removed cost barriers to general practice and primary care services, either through free access (taxation or insurance funded) or

subsidised payments [34]. Ireland is an outlier. Whilst ~45% of the population can see their GP for free (with GMS cards, doctor visit cards, under 6 doctor visit cards), the rest of the population pays full costs of attending GPs, allied professionals and pharmacy costs.

- Providing 'free' at point of care access is positive for population outcomes. However free care increases demand, with increases in contacts with the health system. In a fixed supply system this creates frontloading in terms of capacity and initial cost, but in the long term, costs are powerfully contained, and outcomes improved. 'Free' care for U6s has markedly increased utilisation rates, and capacity is now stretched. Improvements in paediatric asthma care, childhood overweight and reduced admissions will take several years to become evident, particularly given poor present use of information technology.

Insurance:

- ICGP is critical of the failure of Insurance Companies to recognise/ reflect primary care. Given escalating costs of chronic disease management, ICGP recommends all health insurers be required to reimburse fair primary care costs in all insurance products, as a statutory condition of operating in the Irish economy, and that relevant legislation be enacted as a priority.
- ICGP recognises inconsistent incentives supported by most Insurance Companies in preferentially funding hospital-based services at higher rates than when these same services are provided in primary care. Thee incentives require to be removed. An example includes the reimbursement for venesection for haemachromatosis (€400 in hospital setting, but €90 in general practice).
- ICGP recognises the inadequate regulation of use of investigative resources and cross referral between specialists of the insured population, placing patients at risk of iatrogenic illness, adding substantially to medical inflation, and wasteful of finite resources in the context of the total health budget.

Solution(s):

- Universal secondary care: create a single-tier access to secondary care services, as part of an all-party taskforce working with key healthcare stakeholders by either:
  a) a tax-funded, publicly delivered single-tier system, or
  b) a single payer model (with a split in payer and provider functions).

- Universal primary care: ICGP supports increasing access to general practice and primary care, subject to building capacity in general practice and primary care.

[34] European Observatory. Building primary care in a changing Europe. 2015.

12. GP role in Emergency Department over-crowding

- The ED Overcrowding Taskforce recommends reduction in ED Overcrowding, through increasing bed capacity, improving community supports and improving step down facilities [35].
- Well-resourced general practice also reduces unscheduled ED visits. A functioning chronic disease management programme will enable general practice reduce ED visitations and healthcare costs, if undertaken with improved step down facilities and community care packages.
- GP Co-Operatives have potential to assist, with augmented roles in minor injury management, integration with CITs (Community Intervention Teams) and working more closely with ED Departments, including planning, selective use of Co Op colocation in ED Departments, and provision of sessional GPs in EDs.
- Provision of an effective Primary Palliative Care Package will enable more end of life care to be delivered in communities, avoiding unwelcome over medicalisation of end of life, presently a cause of inappropriate unnecessary acute admissions.

Solution(s):

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

13. Health promotion and public health

- ICGP supports Healthy Ireland, the national framework to improve health and wellbeing of the people of Ireland.
- GP Teams are the point of first/ continuing contact in healthcare, and well placed to systematically address unsafe alcohol & tobacco use, stress, obesity and sedentary lifestyles.
- Strong evidence supports consistent brief interventions addressing these risks.
- Given resource contraction in general practice, prevention potential is only partially exploited at present.
- Addressing resource deficits in primary care together with a multi departmental government approach represents the optimal direction in addressing key public health challenges facing Irish society.

Solution(s):

- ICGP recommends government-wide approach to obesity, sedentary lifestyle, problem alcohol use, stress and smoking.
- GP Teams require resources to address health promotion with patients, to build

[35] Department of Health. Emergency Department Task Force Report. 2015.

capacity, and deliver on Healthy Ireland framework.

14. Fragmentation of care

- Continuity of care is key to managing complex patients. In our example, Mrs Smyth's care is fragmented, and her GP service is now compromised.
- GPs and public patients experience at first hand an increasingly complex secondary healthcare environment, with multiple corporate healthcare providers attempting to deliver care and potentialdeleterious effects for patients and broader society.
- ICGP formally alerts government to costs and dangers of fragmented care and corporate 'for profit' environment of modern healthcare.
- ICGP strongly notes the negative effects of corporatization in general practice, which has begun in Ireland. This trend is will affect younger, establishing GPs disproportionately, dissuaded from practicing in Ireland as Principal GPs, with corporate companies filling the gap. Young, establishing GPs need to be supported and incentivised to take up Principle GP positions, not demoralised into taking salaried jobs for profit-making companies.

Solution(s):

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

Appendix 2: Six 'Quick Wins' for Irish Society

1. Payment must cease to be a barrier to essential medical care
2. Universal use of electronic medical records
3. Build capacity in primary care
4. Fully establish chronic disease management in primary care
5. Support end of life care in the community
6. Health Insurers must recognise Primary Care if operating in the Irish economy