NAGP
Cumann Naisiunta na nDochtuiri Teaghlaigh

INITIAL
NAGP SUBMISSION
ON CONTRACT ISSUES AFFECTING GENERAL PRACTICE

SUBMITTED TO

- Minister for Health
- Minister of State for Mental Health, Primary Care and Social Care (Disabilities and Older People)
- Department of Health
- Joint Oireachtas Committee on Children and Health
- HSE

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1. INTRODUCTION

General Practice is the cornerstone of medical care in Ireland and General Practitioners (GPs) are committed to the provision of high-quality services to their patients.
GP services to public patients are provided under General Medical Services (GMS) contracts between GPs and the Health Service Executive (HSE).
The development of a new GP contract is now under consideration which will require meaningful consultation and agreement with all the GPs providing these services.
The National Association of General Practitioners (NAGP) represents a significant number of GPs throughout the country and therefore must be included in the negotiation of the new contract.
This document is an initial submission by the NAGP highlighting major issues affecting the GPs providing the service which have to be addressed in the development of a new GMS contract. The document was drawn up after a national consultation meeting of NAGP members and non-members.
While it is recognised that there are fundamental long-term issues for which detailed long-term planning is required (including care of patients with chronic disease) going forward, this submission focuses on a range of recurring issues which have to be progressed in the short term to meet current unmet needs of GPs in order that high-quality services can be provided effectively.

2. BACKGROUND

In the Republic of Ireland, GPs are self-employed and are responsible for the provision of GP services and the necessary practice infrastructure to deliver the service. In addition to staffing a practice, GPs provide premises and equipment and bear significant costs arising from insurance, as well as locums for holiday cover and sickness cover and business closure costs.
GPs deal with both public and private patients.

2.1 Existing contract model for public patients

The GMS contract for public patients was devised circa 1972. The initial structure was on the basis of fees being paid for each service provided to patients including fees per patient visit. The contract was changed to a capitation system in 1989 due to high costs. The current basic GMS contract is based on the provision of acute care; that is, the treatment of sick people. The contract is a 24-hour 365-days-a-year contract. The management of chronic conditions and prophylactic care was not envisaged in the original contract. The bulk of GP remuneration is based on a capitation payment, ie. one payment per patient regardless of the number of visits to a GP. The remainder of monies to GPs are in the form of allowances for practice support services including secretarial and nursing support. Contributions are also made to a doctor's superannuation fund.
To cover 24-hour care, out-of-hours care is provided via GP co-operatives, of which there are a range of models. The GP co-operatives cover both public and private patients.
The existing model is very cost-efficient for the Government but extremely onerous for GPs.

2.2 Services provided by GPs to public patients

The range of services provided by GPs has expanded significantly over the years. GP services now include inter-alia acute care, chronic disease care, management of complex mental health needs and Special Type Consultations (STCs).
STCs are those additional services not covered by the original acute contract which are separately remunerated.
GPs also provide services to nursing homes and hospitals.
Due to an ageing population and deprivation, the number of patients with multi-morbidities and chronic conditions has increased over time. In light of the evolution and expansion of services, GPs have been calling for new/restructured GP contracts for many years.

2.3 Underfunding of GPs

As the services provided by GPs have evolved and expanded, in particular over the past 10 years, GPs have been under increasing financial pressure. In addition to lack of payments for a range of services, there are fundamental issues in relation to inadequate payments for locum cover for sick and holiday leave. This has caused extreme stress to GPs. Out-of-hours cover, sick leave and holiday relief are essential to allow GPs to practise in a safe and effective manner.
In addition to the increase in scope of services for which GPs are not being properly reimbursed, the Financial Emergency Measures in the Public Interest (FEMPI) cuts to General Practice has put further severe pressure on GPs. As a consequence, some GPs are leaving the system and new GPs are not taking up positions because it is not financially viable to do so.
The extent of underfunding for GP services is a serious issue. The percentage of the healthcare budget in Ireland spent on GP services is in the order of 2.5-3.0%. As a comparison, the budget for GP services in the UK is of the order of 9%. In relation to funding, therefore, the following is required:

- The FEMPI cuts must be immediately reversed;
- The underfunding of the GP service needs to be addressed urgently by the Government.

2.4 Current direction of health policy

Government policy in relation to access to GP care has fundamentally changed in the past five years. It is the Government's aim to have free at point-of-access GP care for all (public and private) under-18s by 2016. This is predicted to considerably increase aggregate GP visiting by former non-cardholders, which will further increase pressure on an already under-resourced system. GPs will have to be properly funded to provide staffing for this workload. As part of a new negotiated contract, allowances need to be built in to enable GP practices to employ extra GPs to cope with the increased pressure for consultations as more patients are brought into the system. This is the only way that GPs can deliver the level of service that the HSE expects.

3. SERVICE PROVISION MODELS

GPs are currently largely self-employed. A fundamental question that needs to be addressed in consultation with the NAGP is whether, in the future, GPs should be self-employed or employees of the state.

3.1 Contract issues

If General Practice is to be made free at point-of-access to increasing cohorts of patients, GPs will essentially be employees of the state, and will require an employee contract based on hospital consultant levels. This will include pension, sick leave and all the usual entitlements of state employees, as well as the provision of premises and staff, IT and overheads.
If, on the other hand, GPs are to remain self-employed with all the risks entailed, in a situation where the state wishes to continue with provision of free GP care at point-of-access, a different system other than the current unlimited visits for a fee decided by the state (which does not reflect the range of services provided by GPs) will be necessary. A basic capitation payment for basic acute services, with a range of additional services paid on a fee-per-item basis, reflecting the resources involved, might be considered. This would have to be combined with contributions towards premises and IT, as well as significant changes in sick leave entitlements and pension.
The idea of making out-of-hours work the subject of a separate contract was discussed by the NAGP and found some favour, giving GPs the option of opting out of this work. Currently, there is wide diversity and inequity in the terms and conditions for GPs across the state regarding out-of-hours work. Large numbers of GPs continue to pay in the region of €6,000 annually to fulfil their 24-hour commitment, thus negating most of their earnings for this work. This is not a sustainable situation and must be addressed.
It was also agreed that a separate contract covering care of patients in nursing homes needs to be considered.
A further issue to be addressed in any future contract is that of GPs having to pay redundancy to long-serving staff, in the event that there is no GP to take over the practice on the GP's retirement. This is a situation which is arising in the current climate of uncertainty in General Practice, whereby young GPs are not willing to take over closing practices, leaving the retiring GP in this vulnerable position.

3.2 Parity of entitlements with public service consultants

GPs are experienced, hard-working, expert clinicians who, in addition to diagnosis of illnesses, are responsible for long-term management of patients after hospital interventions.
GPs should have commensurate rates of pay with consultants, reflecting their level of expertise, training and responsibility. GPs require the availability of locum cover, access to diagnostics, support for IT and buildings and state indemnity at full cost.
GPs should also receive a subsidy or salary for a GP assistant for every contract-holding GP (along with nurse, secretary and practice manager). It should not just be based on panel size. Such staff should receive HSE terms (including pensions, annual leave, maternity leave etc) but the GP would remain their employer.

4. SPECIFIC ISSUES

4.1 Streamlining Special Type Consultations

The benefit of seeing and treating patients in primary care, as opposed to a hospital Emergency Department, is widely acknowledged. GPs have trained and equipped themselves, at their own expense, to carry out many procedures in General Practice. As a result of the drastic cuts in GP funding over the past number of years, GPs are now struggling to provide these services; to continue to do so means providing them at a loss. This is unsustainable.

A new list of Special Type Consultations (STCs) that reflects what General Practice can provide in 2015 and beyond needs to be implemented. The current list is completely out of date and does not reflect modern general practice either in its scope or in the funding provided. A modern list of properly remunerated STC items will lead to many more procedures being carried out in General Practice, increasing patient satisfaction and reducing costs in secondary care.

In addition, funding needs to be provided for the continuing professional development (CPD) necessary to continually upskill and retrain for the ongoing provision of such services.

The NAGP proposes that a new matrix be constructed which lists all relevant STC items and analyses each under a number of headings:

- GP time to carry out the procedure or provide the service;
- Expertise involved in undertaking the task;
- Indemnity required to cover the task;
- Interpretation of subsequent results, eg. histology, etc.;
- Overheads, including staff, the purchase and maintenance of equipment and consumables used.

The following is a non-exhaustive list of items to be potentially included:

- Suturing;
- Minor surgery;
- Joint injections;
- 24-hour blood pressure (BP) and cardiac rhythm monitors;
- Spirometry;
- Sexually transmitted infection (STI) screening;
- Electrocardiograms (ECGs);
- Mental health assessments;
- Mental health certification;
- Lengthy consultations to facilitate patients with multi-morbidities;
- Venesection for haemochromatosis;
- Intrauterine contraceptive devices (IUCDs) and implants;
- House calls;
- Primary care meetings;
- Phlebotomy;
- DXA scanning;
- Ultrasound.

The funding model could work along the lines of the cervical screening model of funding, taking account of upskilling, consumables, administration and time needed to provide the service.

4.2 Supporting rural General Practice

The specific requirements of rural practice need to be addressed in the new GMS contract.
In general, rural practices cover much larger geographical areas than non-rural practices. Typically, rural practices have more socio-economically deprived patients than those in cities or towns.
Limited access to diagnostics hampers the ability of the GP to deliver optimum service.
Many rural GP practices have insufficient income to support essential staff employment due to removal of distance band codes, removal of rural practice grants and other FEMPI cuts; as a result, some practices are now insolvent.
The FEMPI cuts over the past five years have decimated rural practice in Ireland. Morale among rural GPs is at an all-time low, with many rural posts remaining unfilled, some for years after the incumbent GP retiring. This trend is on the increase and will have an untold negative effect on the social fabric of our rural communities.
The following immediate requirements have been identified:

- There should be an immediate restoration of rural practice grants;
- There should be an immediate restoration of distance band codes;
- Properly funded out-of-hours cover, sick leave and holiday relief are essential for rural practices;
- Support grants for IT and practice equipment are required;
- A commitment to resource emergency services in a realistic manner to provide services for rural communities must be prioritised;
- A rural practice weighting should be included in the capitation fee so that rural practitioners' pensions are comparable to that of urban practitioners;
- The option of employee status for rural GPs and their staff should be considered. This is particularly important with regard to staff redundancy issues when GPs retire and the post cannot be filled. If a locum is put into the practice by the HSE, it would be preferable that the secretarial or nursing staff continue in their posts because they are the organisational memory of that practice, so in this case there should be a transfer of responsibilities to the HSE;
- Separate out-of-hours care from the day-to-day care and provide two separate contracts with the option to opt in or opt out of out-of-hours care.

4.3 Supporting urban deprived General Practice and deprivation in general

The specific requirements of urban deprived practice need to be addressed in the new GMS contract.
The effects of an ageing population are felt more keenly in areas of deprivation, as is evidenced by the number of patients with multi-morbidities and chronic conditions, which has increased over time.
There is an urgent need to introduce a deprived area allowance and/or a general deprivation allowance, which should be graded to take account of the difference between areas of greatest need and people in greatest need.
Funding for new GPs should recognise deprivation wherever it exists to encourage new entrants.

The following immediate requirements have been identified:

- Introduce allowances that recognise deprivation;
- Introduce codes to grade the areas of deprivation;
- Properly funded out-of-hours cover, sick leave and holiday relief are essential for urban deprived practices;
- Support grants for IT and practice equipment are required;
- A commitment to resource emergency services in a realistic manner to provide services for deprived urban communities must be prioritised;
- An urban practice weighting should be included in the capitation fee so that urban deprived area practitioners' pensions are comparable to those of urban practitioners in less economically deprived areas;
- The option of employee status for urban deprived GPs and their staff should be considered. This is particularly important with regard to staff redundancy issues when GPs retire and the post cannot be filled. If a locum is put into the practice by the HSE, it would be preferable that the secretarial or nursing staff continue in their posts because they are the organisational memory of that practice, so in this case there should be a transfer of responsibilities to the HSE;
- Separate out-of-hours care from the day-to-day care and provide two separate contracts with the option to opt in or opt out of out-of-hours care.

The NAGP proposes a formal pathway, supported by Government, for post-MICGP (Membership of the Irish College of General Practitioners) graduates, which identifies areas of unmet need in urban deprived regions. This pathway should incentivise newly trained GPs with start-up support grants and/or provide a salary for a three-year contract, and provide staff and premises. The GP would have the option to buy the practice after the three-year period expires, or another newly qualified GP would take it over.

4.4 Resourcing chronic care

There is a significant level of chronic disease in the country, including chronic obstructive pulmonary disease (COPD)/asthma, diabetes, heart failure and atrial fibrillation, musculoskeletal conditions and mental disorders.
Chronic diseases occur more frequently among the poor and vulnerable. The level of chronic diseases is increasing as the population ages.
The care of patients with chronic disease is complex. Many patients have more than one chronic disease, which complicates the care of patients with chronic conditions.
A significant proportion of GP consultations relate to the diagnosis and acute care of patients with chronic disease.
The HSE is looking to roll out the management of chronic disease to GPs. As a first step, the HSE has now included ongoing management of diabetes care as part of GPs' responsibilities, in addition to diagnosis and acute care. The fee proposed is totally inadequate and shows a total lack of understanding of the work undertaken and time spent by GPs in managing diabetic patients who can have a significant level of disability and often require substantial care on returning to the community after hospital admissions.
The NAGP is seeking to have chronic disease management included in the new GP contract. The specific tasks to achieve such care will have to be devised in consultation with the NAGP.
The provision of chronic care will have to be properly funded and resourced.

4.5 Retaining newly trained GPs

The NAGP is very concerned about the lack of incentives and support provided for newly trained GPs to encourage them to stay in Ireland, and support them in taking up existing practices and setting-up in general practice.
The nature of contracts and cost of starting up a new practice are prohibitive for young GPs.
The following immediate requirements have been identified:

- Infrastructural payments should be separate from capitation payments, IT payments and equipment payments;
- The NAGP would favour the introduction of start-up grants and/or a rent-support scheme;
- Funding should be linked to areas of deprivation scores;
- The costs associated with Health Information and Quality Authority (HIQA) compliance can be considerable and need to be funded by grants.

5. SUMMARY

The development of a new General Practitioner (GP) contract is now under consideration and requires meaningful consultation with the GPs providing the service.
The National Association of General Practitioners (NAGP) represents a significant number of GPs throughout the country and, therefore, must be included in the negotiation of the new contract.
This document is an initial submission by the NAGP highlighting major issues affecting the clinicians providing the service, which have to be addressed in the development of a new GP contract. The document was drawn up after a national consultation meeting of NAGP members.
The range of services provided by GPs has expanded significantly over the years. Furthermore, due to an ageing population and deprivation, the number of patients with multi-morbidities and chronic conditions has increased over time.
Given the evolution and expansion of services, in particular over the past 10 years, GPs have been under increasing financial pressure. In addition to a lack of payments for a range of services, there are fundamental issues in relation to inadequate payments for locum cover for sick and annual leave. This has caused extreme stress to GPs.
In addition to the increase in scope of services for which GPs are not being properly reimbursed, the Financial Emergency Measures in the Public Interest (FEMPI) cuts to General Practice has put further severe pressure on GPs.
As a consequence, a significant number of GPs are leaving the system and new GPs are not taking up positions because it is not financially viable to do so.
The extent of underfunding for GP services is a serious issue and needs to be immediately addressed. The FEMPI cuts need to be immediately reversed.
A fundamental question that must be addressed in consultation with GPs is whether, going forward, GPs will be treated as self-employed or as state employees.
Some areas in General Practice where increased support will yield benefits to patients are identified and include:

- Streamlining Special Type Consultations;
- Supporting rural General Practice;
- Supporting urban deprived General Practice and people in greatest need;
- Properly resourcing chronic disease management in General Practice;
- Retaining newly trained GPs.

Finally, the NAGP calls on the Government to set up a working group of all key stakeholders from health, educational and justice to attempt, once and for all, to identify and manage the real issues involved in resolving the long-term consequences of deprivation.

NOTES

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