NAGP

Cumann Naisiunta na nDochtuiri Teaghlaigh

PRE-BUDGET SUBMISSION 2017

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The National Association of General Practitioners (NAGP) is an Irish registered company limited by guarantee. The company was incorporated in 2013 but the organisation dates back to 1987. The NAGP represents the interests of GPs in Ireland and currently has approximately 1,600 members.

1.0 Executive Summary

The National Association of General Practitioners (NAGP) represents more than 1,600 general practitioners (GPs) across the country. For this reason, we are in a unique position to discuss the pressures facing GPs across the country, and also, to suggest proposals which would facilitate improvements to the framework in which our members work. Since 2009, GPs have absorbed a major increase in workload by working longer hours and increasing consultations. As a result, the system of general practice is starting to to creak and patient safety is now at risk. As a result of the under-6s scheme, waiting lists are now commonplace in general practice throughout every part of Ireland, for the first time in three decades.

The pressure being placed on general practice is creating problems throughout the health sector, as seen in emergency departments and other areas of health. The crisis will lead directly to greater pressure in the hospital sector in the future if it is not addressed.

The need for investment in general practice and primary care is now at a critical level and the Government must acknowledge this in order to maintain the sector; otherwise, deterioration in service levels and increased cost to the health service are inevitable. The NAGP is a solutions-driven organisation and, along with identifying the issues facing general practice, we have also put forward a number of suggestions which we believe could be of considerable benefit to the Irish health sector. These include proposals for reform of primary care centres and reform to the debt burden of medical graduates. Budget 2017 should be viewed as an opportunity to utilise Ireland's economic growth to invest in public services.

Overview of GPs in Ireland

A 2015 LHM Casey McGrath report commissioned by the NAGP, states that there are a total of 2,954 full-time equivalent GPs in Ireland, which gives a rate of 64 GPs per 100,000 of population. The number of Irish GPs is well below the rate for Organisation for Economic Cooperation and Development (OECD) countries which have good primary care facilities, such as the UK, Australia and Canada.

The number of medical cards and GP-visit cards has increased substantially over the past decade. From a base of approximately 28% in 2004, over 40% of the Irish population now has a medical or GP card. Financial Emergency Measures in the Public Interest (FEMPI) cuts have led to GPs struggling to operate a financially viable business and to the departure of many experienced GPs to other jurisdictions.

A 2015 survey has shown that 31% of GPs intend to retire or leave the profession in the next 3-5 years, while 66% would not recommend general practice as a profession to their children. The trend of young GPs emigrating looks set to continue – another recent survey showed that only 25% of GP trainees intend to stay in Ireland. The reason cited by most was the uncertain viability of general practice in Ireland in the future.

We do not have enough GPs, and are losing many more than we should to other countries. This will lead to serious problems in the future. At the same time, investment in primary care is shown to be hugely important in reducing the overall health spend without affecting patient care.

Number of consultations

The number of consultations per year is disputed among statisticians but, combining figures from the Central Statistics Office (CSO), the Economic Social and Research Institute (ESRI) and a 2013 *Irish Medical Journal* (IMJ) study, the average attendance rate for General Medical Services (GMS) patients is 7.71 per year, while for private patients it is 3.07. The attendance rates for children under six years of age have a similar gap, at 5.8 visits for GMS patients and 2.7 for private patients.

Evidence from the UK suggests that children under six attend their GP seven times per year. One year after the introduction of free GP care for under-6s in Ireland, we do not have statistics to confirm an increase in attendance, although GPs have indicated significant increases within their own practices. The anticipated increase in consultations in Ireland from 2.7 to 5.8 per annum, without any corresponding increase in GPs, is likely to lead to a deterioration in care in a number of areas.

Time spent with patient

The average time spent with a patient varies, but 15 minutes is the recommended time. In the UK, it is 12 minutes and in Australia, it is 14. A recent independent study indicates that 50% of Irish GPs spend an average of 12 minutes per patient and 35% have seen patient time reduced in the past 12 months.

Waiting times

Another recent survey showed that 53% of routine appointments are seen on the same day, while the figure for emergency appointments is 97%. However, the same survey showed that GPs expect this to drop to 6% and 62%, respectively, following the introduction of free GP care for under-6s.
In the UK, an estimated 60 million consultations out of a total of 340 million have to wait for more than a week. The proposed expansion of free GP care to all children under the age of 18 will, inevitably, increase waiting times for patients and a large body of research has shown the negative impact of waiting times on morbidity.

Patient safety

It is an obvious conclusion that if GPs have to rush patients, or ask them to wait for several days for an appointment, the quality of primary care will suffer. The viability of house calls, specialist treatments and out-of-hours care are also called into question.

Degradation of GP sector

Recent trends show that GP practices are increasing in size, resulting in fewer GP practices and a decrease in overall spread. Only 1.7% of graduates see themselves as being sole practitioners. This has resulted in the closures of rural practices, which are often single-handed, as new GPs are not willing to take them over. However, the expansion of the Rural Practice Support Framework in 2016 does provide reasons to be optimistic for the provision of general practice in rural areas.

Future of GP sector

The Government plans to introduce free GP care on a phased basis for those aged under-18. This is certain to increase the number of GP consultations per year. It is anticipated that 1,310 new GPs will be required to keep pace with the expected rise in consultations. The current level of GP trainee places per annum is 157 and, as mentioned earlier, most of these trainees do not intend to remain in Ireland. The Government does plan to increase the number of trainee GPs by 100 per year.
Given that 31% of GPs intend to retire or leave the profession in the next five years, there will be a major shortfall in GPs and the numbers will not be sufficient to maintain current standards. As mentioned earlier, these current standards are well behind other OECD countries.
As a first step in recruiting future GPs, action needs to be taken now to make practices viable and attractive to trainee GPs, as well as retaining, our current crop of GPs. We also discuss, below, the consequences of the debt burden of medical graduates, which research shows is a deterrent to GPs considering becoming a trainee GP.
The GMS funding per GP consultation in 2008 was €41.47. In 2013, it had declined to €29.42. To maintain even this low level of funding in 2021, at 2013 levels, according to current projections, would require an increase from €447,815,338 to €989,967,020 per annum. That's an increase in funding of €542,151,682 just to keep pace with 2013 levels, which, as we have stated, will not be enough to retain current GPs and entice more into the sector.

Conclusions and suggestions

The new Government has made some progress, particularly in the expansion of the Rural Practice Allowance Framework. However, the future of a viable GP sector in Ireland is still in doubt. Measures need to be taken now to ensure the medium and long-term viability of the sector. The trends of practice closures and GP emigration need to be reversed. Efforts must also be made to attract Irish-trained GPs who are working abroad to return to Ireland. We are now beginning to see the entry of graduate medical students into general practice. These

new entrants are saddled with a considerable level of student debt, which makes practising in this jurisdiction challenging.

Having engaged in very broad consultations with GPs over the past three years, the NAGP firmly believes that this can only be done by reversing FEMPI cuts and introducing a range of measures that will allow Irish general practice to compete with other nations in order to ensure that the Irish health system is an attractive environment for Irish doctors to work in.

The pressures that have been placed on general practice since 2008 have led to its slow but constant decline. It will take a long time to restore it to its former level and, indeed, increase its capacity for the future.

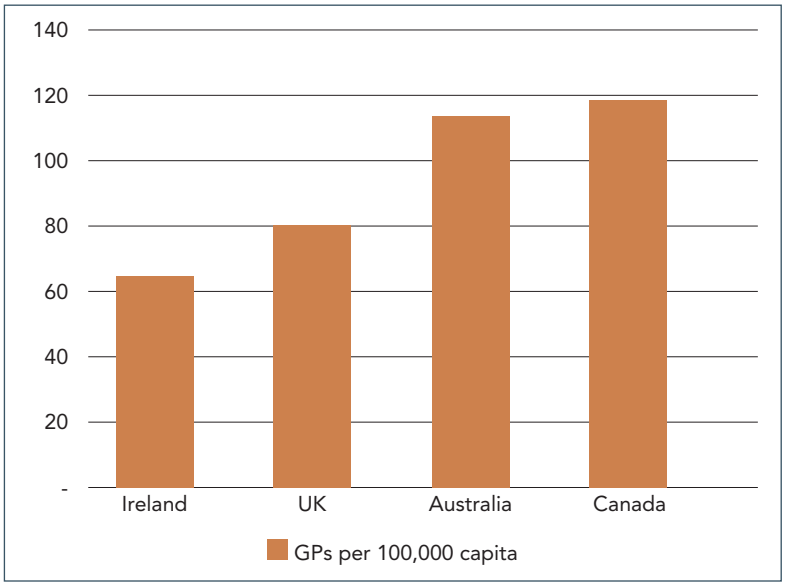
Investment in primary care can reduce the overall healthcare spend, while increasing general health and wellness. We are asking Minister for Health, Simon Harris, to abolish the FEMPI cuts and invest further in general practice to prevent a looming crisis for patients in the primary care sector.

2.0 GPs in Ireland

The most recent official statistics estimate the population of Ireland to be 4.61 million, with approximately 430,000 of those aged less than six years old.[1] The country has a continually increasing population and it is expected to be 5.19 million by 2031.[2] The average life expectancy rates, which are now at 79 for males and 83 for females,[3] have also been on the rise, and the population aged 65 and over has increased by 14.4% since 2006.[4] The effects of patients living longer, often with complex and multiple health conditions, are likely to lead to an increase in the number of GP consultations and, as a consequence, an additional strain on GP practices.

The number of GPs with a General Medical Service (GMS) list, which is discussed further below, stood at 2,413 in 2014.[5] However, this figure does not include GPs who are working without a GMS list or working as salaried GPs. A recent study suggests that there are a total of 2,954 full-time equivalent GPs in Ireland.[6] This gives a rate of approximately 64 GPs per 100,000 of population for the country. As shown in the table below, this is well below the rate, as per the OECD, for countries with internationally renowned primary care facilities such as Canada and Australia.

Table 2.1: GPs per 100,000 capita population.



A GP will treat members of the public that are assigned to their GMS list for free. The State will then pay the GP a standard annual fee for each patient on their GMS list regardless of the number of standard consultations provided. The patient on the list will be in possession of either a medical card or a GP-visit card. These cards are primarily issued based on the medical needs and the level of income of the patient.

The table below shows the number of cards issued over the past 10 years.

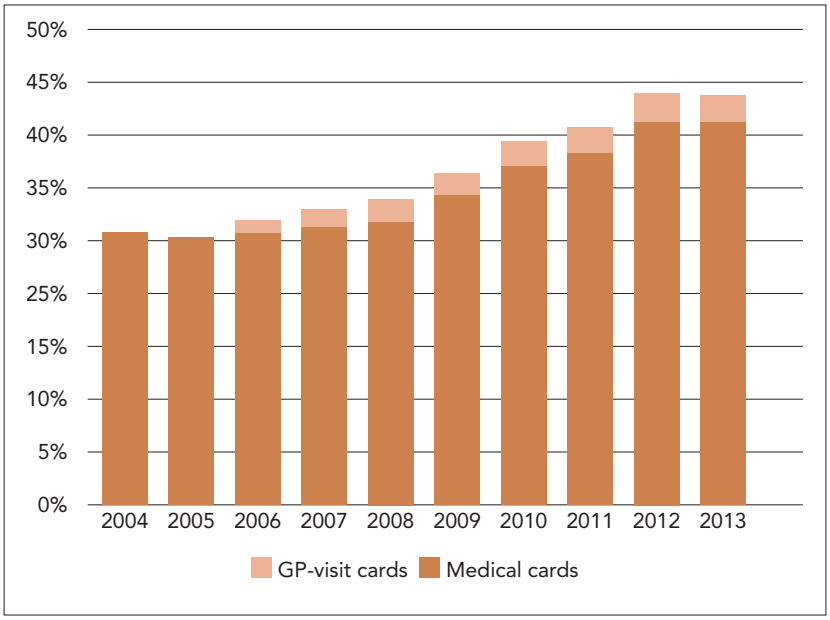
Table 2.2: Medical card and GP-visit card data.[8]

Year	Total medical cards	% of total population	Total GP-visit cards	% of total population
2004	1,148,914	28.4%	n/a	n/a
2005	1,155,727	28.0%	5,079	0.1%
2006	1,221,695	28.8%	51,760	1.2%
2007	1,276,178	29.2%	75,589	1.7%
2008	1,352,120	30.1%	85,546	1.9%
2009	1,478,560	32.6%	98,325	2.2%
2010	1,615,809	35.5%	117,423	2.6%
2011	1,694,063	37.0%	125,657	2.7%
2012	1,853,877	40.4%	131,102	2.9%
2013	1,849,380	40.3%	125,426	2.7%

Preliminary statistics for 2014 indicated that the figures are likely to be broadly in line with 2013.[9]

The number of medical cards and GP-visit cards issued in Ireland has increased substantially over the past decade, which is clear from the graph below.

Table 2.3: Population with a medical card or GP-visit card.



It is clear that the GP sector has been expected to care for an increasing number of medical card, or GP-visit card, patients over the past 10 years. The strain of providing care to more patients with less funding is now showing in the sector.

A recent survey has shown that 31% of GPs plan to retire, or leave the profession, in the next three to five years, while 66% of GPs would not recommend the profession to their children.[10] This is considered to be a worrying trend as, anecdotally, there has been a tradition in Ireland of children following in their parents' profession as a GP. The trend of young, trained GPs emigrating from Ireland also looks set to continue. A recent survey of GP trainees shows that only one quarter will definitely remain in Ireland while the rest have decided to emigrate, or are considering emigration, with Canada and Australia the most popular destinations.[11] The primary reason cited is the viability of general practice in Ireland in the future. The GP sector, therefore, has a lack of young trained GPs coming through the ranks. This is a significant problem which is not being dealt with and is expected to lead to long-term problems in the sector.

International evidence and studies suggest that an increase in the quality of primary care will have significant benefits to the overall health of a country. In Rhode Island, USA, for the years 2008-2012, a 37% increase in primary care spending resulted in an overall decrease in the health spend of 14%.[12] The Commonwealth Fund produced a report in 2012 estimating a sixfold return, on overall health spending, if there was an increase in Medicare Fees to GPs[13] while a Deloitte report, for the Royal College of General Practitioners in the UK, suggests a fivefold return.[14] However, in Ireland since 2008, there have been significant cuts to the GP sector under the Financial Emergency Measures in the Public Interest (FEMPI) Act. These cuts are estimated to have been approximately €960m in total between 2008 and 2014.[15]

All of the above depicts a profession which is at risk and in need of additional resources, funding and manpower.

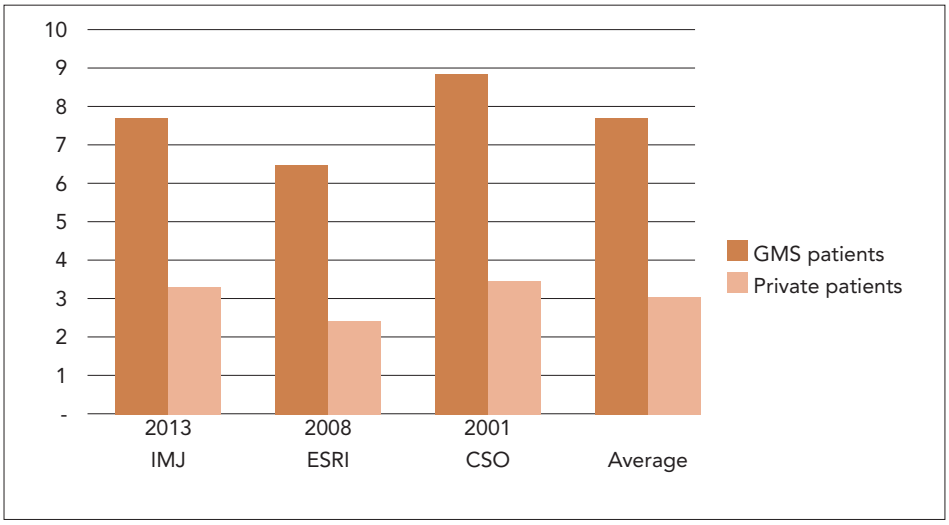
3.0 Number of consultations

The statistics regarding the number of annual GP consultations have been the cause of some debate due to the argument that the official figures, from the CSO, are underestimating the true figure.[16]

The 2007 and 2010 CSO surveys used a recall period of 12 months, when questioning the participant, which has been shown in a number of studies to produce inaccurate results.[17] The 2001 CSO survey was completed using a shorter recall period of two weeks which it could be argued produced more accurate results. The 2014/2015 CSO survey, which is currently underway,[18] has amended the recall period to four weeks. It is anticipated that, because of the shorter recall period, the survey will result in higher attendance rates than those reported in the preceding two CSO surveys.

The graph below reflects the statistics from a 2013 survey published in the *Irish Medical Journal*,[16] a 2008 ESRI study[19] and the official CSO statistics from 2001 in relation to the average annual number of consultations.

Table 3.1 Average number of annual GP consultations.



As shown in the graph above, the average attendance rate for GMS patients is 7.71 consultations per annum while for private patients it is 3.07. The attendance rates for under-6s are shown to have a similar gap at approximately 5.8 visits for GMS patients and 2.7 visits for private patients.[20] It is therefore clear that an individual in possession of a medical card will, on average, visit a GP more often than a private patient.

However, the question arises: if an individual receives a medical card, will their GP attendance rate increase despite no deterioration in their health? The health system in the UK provides the most readably available juxtaposition. It has been shown in the UK that GP attendance rates can vary somewhat, based on socioeconomic backgrounds, in the 30-70-year-old categories. However, a study in the UK has shown that children will attend their GP at similar rates despite their varying socioeconomic background.[21]

As mentioned previously, in Section 2, the population of under-6s in Ireland is approximately 430,000, of whom approximately 65%,[8] or 279,500, did not possess a medical card prior to the introduction of the Scheme. If these children attend their GP 5.8 times per annum, as opposed to the previous rate of 2.7, this could lead to an increase of 866,450 consultations per annum at a minimum. It is also worth noting that a report published in 2009 in the UK indicated that, in fact, under-6s attend their GP, on average, approximately seven times per year.[22] This anticipated increase in consultations from 2.7 times per annum to 5.8 times per annum, without an increase in the capacity of GP practices, is likely to result in a deterioration of the care provided in a number of areas as outlined below.

4.0 Time spent with patients

The importance of a GP spending sufficient time with their patients has been well documented and discussed. Studies have shown that a decrease in consultation times impacts negatively on diagnosis and management of long-term health, higher prescription rates, higher referral rates and less preventative care or health promotion.[23] It is, therefore, vital that a GP has adequate resources to spend sufficient time to meet their patients' needs.

The time spent with a patient will vary depending on their medical needs but an average of 15 minutes is the recommended time.[24] The average consultation time in the UK is approximately 12 minutes[25] while in Australia it is 14 minutes.[26] There is little historical data for average consultation times in Ireland, however the anecdotal evidence would suggest an average of between 10 and 15 minutes. However, a recent survey, carried out independently on behalf of the NAGP, indicates that almost 50% of GPs spend an average of 12 minutes per consultation and 35% have seen patient time reduced in the past 12 months.[27] This indicates that average consultation times in Ireland are below the recommended rates.

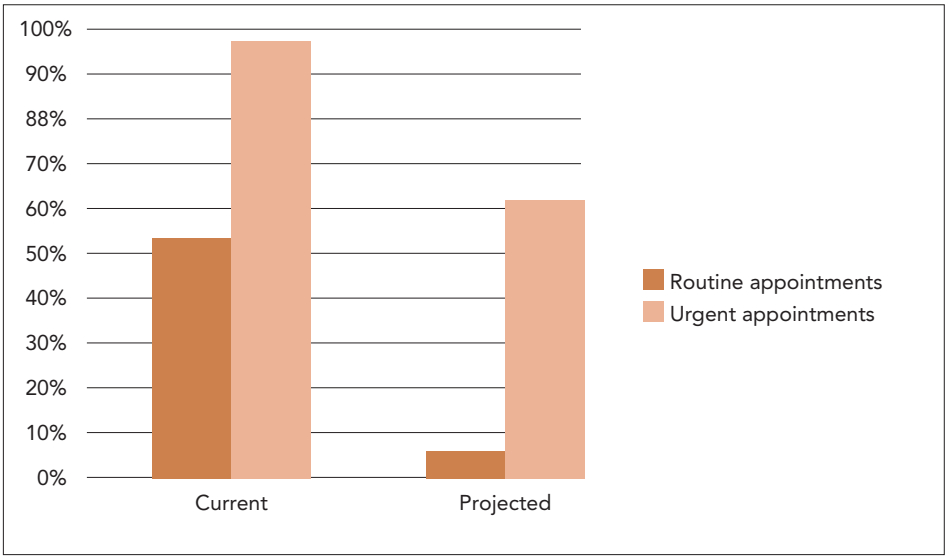
An increase in GP consultations, as described in Section 3, would exacerbate the problem by reducing the average consultation time further. Ninety-four per cent of Irish GPs expected their average consultation time to reduce further following introduction of the Scheme.[27]

In the UK, a minimum consultation time of 10 minutes was recently proposed. The purpose of this was to improve overall patient care in general practice. However, GPs in the UK successfully argued that some patients require consultations of less than 10 minutes. The introduction of this measure, without an increase in the GPs' capacity, would lead to a decrease in the consultation time for those most in need. The measure was discarded by the NHS and responsibility for determining appropriate consultation time was given to GPs. This is a clear example of a government listening to the concerns of GPs and acting accordingly to ensure the needs of patients are met.

5.0 Waiting times

A recent survey of Irish GPs has shown that 53% of routine appointments are seen to on the day while the corresponding figure for urgent appointments is 97%.[28] However, the same survey has shown that GPs expect these figures to drop to 6% and 62%, respectively, with the introduction of the Scheme. As shown in the graph overleaf, this expected drop is significant.

Table 5.1: Patients treated by GP within one day.



The situation in relation to patient waiting times has deteriorated in the UK to such an extent that an estimated 60 million annual consultations, out of a total of 340 million, have a waiting time of more than one week.[29] If the experience in Ireland is similar to that of the UK, any expansion of free GP care, is likely to lead to an increase in patient waiting times.
The importance of reducing waiting times, across all aspects of the health system, is discussed ad nauseam in Ireland and in other countries. Studies have shown that there is a direct link between increased waiting times across the health sector, including GP referrals, and the number of avoidable patient deaths.[30]
If GPs are not sufficiently resourced to cope with the expected increase in GP consultations, as described in Section 3, it is expected to lead to an increase in waiting times.

6.0 Patient safety

The above points indicate that the implementation of the Scheme may result in patients waiting longer for an appointment and having shorter consultations. The viability of services such as house calls, out-of-hours consultations and specialist treatment may prove challenging for some practices. If this is be the case, it is likely that the level of quality primary care offered to patients may also suffer.

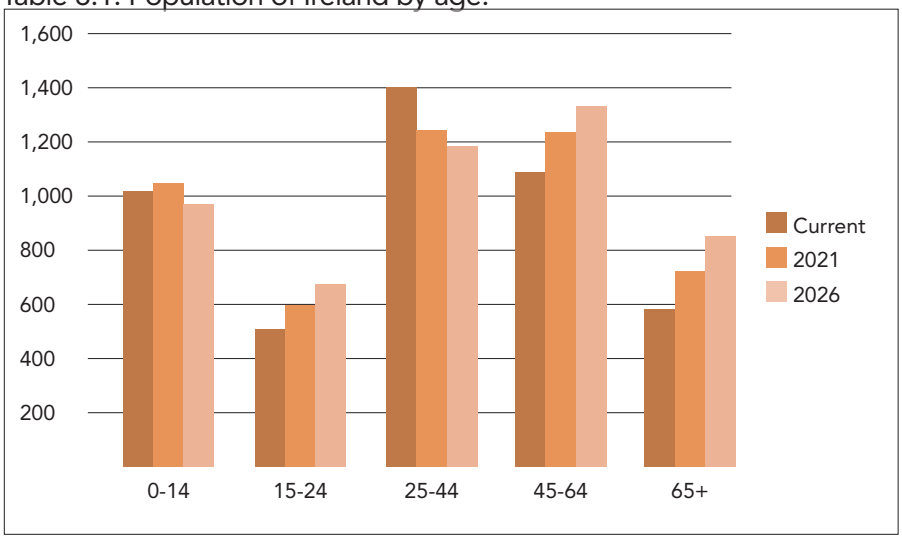
7.0 Degradation of GP sector

The GP sector is currently undergoing change which may have a profound effect on how primary care is provided in Ireland. The general trend has shown a move from smaller to larger GP practices.
A recent survey of GP graduates showed that only 1.7% see themselves as being a sole practitioner.[11] This has resulted in the closure of GP practices in rural and deprived urban areas, which are often single-handed as new GPs are unwilling to take them over when the incumbent retires.
The removal of the rural practice subsidy when the incumbent GP retires is likely to be a contributory factor to this trend.
The current trend of GP practices increasing in size is resulting in fewer overall GP practices and a decrease in their geographical spread. As a consequence, patients in some areas are likely to have to travel much further distances to attend their GP. This is a significant problem for isolated and immobile patients who may not be able to travel longer distances to their GP. This could lead to patients, both private and medical card holders, foregoing medical treatment due to lack of access to a GP. An example of this scenario has occurred in the community of Coolgreany, Co. Wexford.
This community has been without a GP since 2011 when the incumbent emigrated to Australia.[31] This scenario is replicated around the country, with an estimated 30 vacant positions with GPs unwilling to take over due to concerns over their viability.[32] A GP practice is the first point of contact in the community for health issues and the removal of the practice from a community will have profound effects on the people of the area.

8.0 Future of GP sector

As mentioned in Section 2, the most recent official statistics estimate the current population of Ireland at 4.61 million. The total population is expected to increase to 4.88 million by 2021 and to 5.04 million by 2026.[2] As shown in the graph below, the population is also ageing considerably with a significant increase in the 45-64 and over-65 categories expected.

Table 8.1: Population of Ireland by age.



Population of Ireland by age

The 2011-2016 Programme for Government committed to the introduction of free primary care, with extension to claimants of the Long-Term Illness Scheme in the first year and claimants of the High-Tech Drugs Scheme in the second year. The next phase of implementation was to be the introduction of access to subsidised care for all and finally, the provision of care without fees to all patients.[33]

However, following election, Government plans were revised and the decision was taken to introduce free GP care according to age cohorts, beginning with children aged five years and younger. In the most recent Programme for Government, the stated intention is to extend free care to all children under 12 years by the end of 2016.

If, by the year 2021, the universal model is introduced, the total projected population of 4.88 million will be eligible to visit their GP free of charge.

This is likely to result in a significant increase in the number of GP consultations per annum. In Northern Ireland there are approximately 12.7 million consultations per annum,[34] which equates to an approximate average visitation rate of 6.9 per annum based on a population of 1.84 million.[35] If the visitation rate evident in Northern Ireland was to be replicated in Ireland it would likely lead to an increase in annual GP consultations.

As shown in Table 8.2 below, the combination of an increasing population and the introduction of free GP care are likely to result in an overall significant increase in annual GP consultations and having shorter consultations.

The viability of services such as house calls, out-of-hours consultations and specialist treatment may prove challenging for some practices. If this proves to be the case, it is likely that the level of quality primary care offered to patients may also suffer.

Table 8.2: Projected increase in GP consultations.

Year	GMS patients or future equivalent	Visits per annum	Total GMS visits	Private patients or future equivalent	Visits per annum	Total private visits	Total GP visits
Current	1,974,806	7.71	15,219,172	2,635,094	3.07	8,089,739	23,308,910
2021	2,140,190	6.90	14,767,313	2,735,810	6.90	18,877,087	33,644,400
2026	2,251,573	6.90	15,535,851	2,792,427	6.90	19,267,749	34,803,600

Based on Table 8.2 above, by 2021 the number of annual GP consultations is likely to have increased by 10.3 million and by 11.5 million by 2026. If the level of GP primary care, at the very minimum, is to maintain its current level of service then it is anticipated that additional resources and manpower will need to be provided to deal with these additional consultations.

The table below indicates the number of GPs required, to maintain the current standards, to cope with the anticipated increase in annual consultations. The table is based on the assumption that GPs are currently working to their maximum capacity.

Table 8.3: Projected number of GPs required.

Year	Number of GPs	Annual consultations	Annual consultations per GP
Current	2,954	23,308,910	7,891
2021	4,264	33,644,400	7,891
2026	4,411	34,803,600	7,891

Based on Table 8.3 above, by 2021 it is anticipated that an additional 1,310 GPs will be required to keep pace with the expected increase in consultations. The number of GP trainee places available per annum is 157,[36] which is not sufficient to meet the demand. As mentioned in Section 2, a significant number of these trainees do not intend to remain in Ireland once they are qualified and it is also expected that a number of current GPs will be retiring in the next five years. It is, therefore, highly unlikely that the number of GPs in Ireland by 2021 will be sufficient to maintain the current standards given the expected increase in the number of consultations arising from the introduction of the Universal GP Model of Care.

It should be noted that the above tables are only a reflection of what is required to maintain the current standards. As previously shown in Table 2.1, the number of GPs in Ireland is well behind countries such as Canada and Australia. It is therefore possible that Ireland will fall further behind these countries.

As discussed in Section 4, the current evidence suggests that the average GP consultation time in Ireland is approximately 12 minutes while the international recommended is 15 minutes. The introduction of the Universal GP Model of Care and the expected increase in consultations will likely have an effect on average consultation times.

Table 8.4 below shows the projected effect on the average consultation times by 2021 based on the expected increase in the number of consultations described above. They are based on the assumption that GPs are currently working 94,688 minutes per annum for standard consultations. Studies have shown that GPs spend approximately 20% of their total time on paperwork after consultations.[37] This would, therefore, suggest that GPs would be required to work approximately 118,360 minutes to deal with their standard consultation requirements and their additional administration requirements. This indicates that a standard working week, required to deal with these two elements of a GP's commitment, equates to a 41 hours for 48 weeks of the year.

Table 8.4: Projected effect on consultation times.

Year	Annual consultations	Average consultation time (mins)	Total consultation time (mins)	Total number of GPs required	Consultation time required per GP per annum (mins)
Current	23,308,910	12.00	279,706,920	2,954	94,688
2021	33,644,400	15.00	504,666,000	5,330	94,688
2021	33,644,400	12.00	403,732,800	4,264	94,688
2021	33,644,400	10.00	336,444,000	3,553	94,688
2026	34,803,600	15.00	522,054,000	5,513	94,688
2026	34,803,600	12.00	417,643,200	4,411	94,688
2026	34,803,600	10.00	348,036,000	3,676	94,688

The table above indicates the number of GPs required, based on the expected increase in overall consultations, to continue working the current standard of 41 hours per week. If the current number of GPs remained static at 2,954, and the average consultation time remained at approximately 12 minutes, this could lead to an increase in the workload per GP. The table below projects what the increase could be by 2021 and 2026.

Table 8.5: Projected effect on workload per GP.

Year	Annual consultations	Average consultation time (mins)	Total consultation time (mins)	Total number of GPs	Consultation time required per GP per annum (mins)
Current	23,308,910	12.00	279,706,920	2,954	94,688
2021	33,644,400	12.00	403,732,800	2,954	136,673
2026	34,803,600	12.00	417,643,200	2,954	141,382

Based on Table 8.5 above, this potential increase in GP workload is significant. When the administration aspect of these consultations, as described above, is factored in the GP working week could increase to 59 hours by 2021 and 61 hours by 2026. As mentioned in Section 2 there have been significant cuts to the GP sector in recent years. The introduction of the universal GP model of care would clearly require an increase in funding to the sector. However, the information released by the Government in relation to the cost, and funding, has been vague and lacking in specific details.

The table below projects the funding required, to maintain the 2013 average funding per consultations rate, to cope with the increased number of consultations the sector is expected to deal with. The 2008 and 2013 figures for consultations are based on the number of medical and GP visit cards, as shown in Table 2.2, and an average visit rate of 7.71.

Table 8.6: Projected funding required.

Year	GMS Patient Consultations	Funding for GMS Consultations	Funding per GMS Consultation
2008	11,079,613	€459,476,086	€41.47
2013	15,219,172	€447,815,338	€29.42
2021	33,644,400	€989,967,020	€29.42
2026	34,803,600	€1,024,075,810	€29.42

Based on Table 8.6 above, the GP sector is likely to require additional annual funding of €542m by 2021 and of €576m by 2026. If this funding is not forthcoming it is anticipated that the patterns of GPs' emigration, closure of small practices, increase in waiting times, decrease in consultation times, increase in GP workload and the other problems mentioned in this report may continue.

9.0 Specific Policy Proposals

Primary Care Centres - Prioritising Investment in Human Capital

The Programme for Government 2016 seeks a 'decisive shift' to primary care as a solution for our island's health needs. The 10-year consensus plan currently being developed by the new Oireachtas Health Committee has called for ideas on how we can achieve this. For primary care and primary care teams (PCTs) to deliver, there is a need for human, as well as physical infrastructure. This includes the need for greater staffing as well as agreement where they should be best placed to deliver cohesive, effective and cost-efficient care for our population.
Clinician-led projects drive hospital innovation. Similarly, GP-led primary care should be central to integrated services in the community and at the interface with hospitals. There is now a choice to be made: do we continue to focus primarily on buildings or do we develop the human and professional engagements of PCTs in a way that allows all health professionals and GPs to engage equally?

Primary Care Centres

A significant number of primary care centres (PCCs) have already been built and the Government has recently committed to building a further 80 facilities. The original idea of PCCs was to enhance the concept of PCTs and provide better health outcomes for patients at a primary care level.
While enhancing primary care is to be lauded, existing PCCs are under-utilised and have not delivered their full potential.
In response to this, the Department of Health now has a unique opportunity to develop a new, inclusive GP-led system for primary care that can serve as a resource to all healthcare providers and deliver health and social care to all patients.
To date, it is clear that PCCs have not yet achieved their desired level of cohesiveness or effectiveness. They will continue to struggle to get buy-in from the majority of GPs so long as they are perceived to be accessible only to a limited number of doctors who are able to move their practices into the centres for either geographical or logistical reasons.

Change of direction

New solutions for PCT development are needed which can build upon the Primary Care Partnership Consensus document launched in April 2016.
There is now an opportunity to develop a new national system of GP-led primary care, in partnership with the HSE and the Department of Health, to build resource structures in the community that enhance the health and social care of all patients.
Over the last six months, the NAGP has engaged in wide-ranging consultations with stakeholders. Following this process, we believe that a much more effective utilisation of PCCs is possible. The NAGP sees an opportunity for Ireland to follow international examples, turning PCCs into true resource centres on the basis that diagnostics and services in the centres would now be available to all GPs/patients in the locality. Currently, PCCs only benefit a small number of GPs and patients. If re-designated as 'resource centres' they can serve as diagnostic and service hubs that support patient-focussed care with full engagement of local GPs. This model would mean that these resource centres in themselves may not always serve as locations for GP practices, but would serve as resource centres for all GPs/patients in a designated catchment area.
Currently, PCCs are not utilised by the majority of GPs, healthcare providers or patients. The current model of PCCs tends to create divisions in general practice, as GPs who are located in the centres are perceived to have a State-supported advantage over those GPs who are unable to move into PCCs. This puts these GPs and their patients at a disadvantage.

GP-led primary care resource centres

If all GPs in a locality buy into the concept of one primary care resource centre (PCRC), this allows all to refer equally through one agreed pathway to podiatrists, dieticians, physiotherapy, occupational therapy, public health nurses, etc.

Local and regional liaison among practices can be formalised. This would enable innovation and economies of scale for new developments. Supports for local integrated care would be accelerated and patient outcomes improved.

New PCRCs could have a major role in developing social inclusion in healthcare, attracting engagement from mental health and addiction services, counselling (SHIP/CIPC), Traveller health and other voluntary services that are active in primary care. PCRCs could also be a focal point for local engagement with other State agencies such as Tusla — Child and Family Agency, the Department of Education and Skills and the Department of Arts, Heritage, Regional, Rural and Gaeltacht Affairs, etc.

A shared GP-HSE Governance and Development Committee could provide oversight and develop local and regional care pathways with access to diagnostics at the PCRC in an agreed manner. This would energise PCTs and transform PCCs into fully-functional primary care resource centres. The presence or absence of GPs on some sites would not impede development of PCTs or patient services.

This proposal would create an environment where PCTs can deliver for patients and would bring all GPs and health professionals into the same process regardless of where their practice was physically situated. A shared PCRC would re-invigorate the building of PCTs, assist in creating a single integrated health system, and allow a platform that can be scaled nationally.

Benefits of PCRCs:

Puts the patient first;

Changes the culture towards engagement;

Solves the impasse on PCT development;

Supports PCTs to deliver their full potential;

Allows all GPs and health providers to engage with the new PCRC structure;

Allows all GPs and patients equal access to PCRC facilities;

Allows shared governance and development of PCRCs;

Creates a service hub for all patients;

Creates an agreed access point to develop local diagnostics;

Builds community-based centres that can develop new services;

Develops and houses new integrated services with secondary care;

Supports social inclusion in healthcare through community participation;

Assists primary care in reaching its potential for more care in the community; and

Assists primary care in being more self-sufficient with less reliance on hospitals.

Proportionate application of FEMPI to GPs

Since 2009, funding to general practice has been cut by up to 40%, while the impact of FEMPI on the wider health service has been significantly less.

As a result of FEMPI, resourcing in general practice has been a critical issue for the last seven years. Many NAGP members have put a brave face on the struggles that they have felt. Ultimately, due to the financial cuts, they have not been able to continue to provide services to patients that they provided prior to the introduction of FEMPI.

In 2014, Dr William Behan wrote that between 2002 and the 2013 FEMPI/Haddington Road reduction, average State funding per HSE employee rose by 50 per cent due to increments for time in service, grade inflation and provision for pensions.[38] The consumer price index increased by 24 per cent, but payments to general practice per GMS patient were lower in 2013 than they were in 2002.

According to Dr Behan, the recently-published OECD earnings data for Irish GPs show that if the Haddington Road cuts had been applied to general practice in the manner in which the were applied to civil service and other public sector workers, less than €5m would have been taken.

The NAGP urgently calls for an unwinding of the FEMPI cuts introduced to general practice in 2011 and 2013. This would release €70m into general practice and would provide interim relief for a service which is facing increasing pressures due to the difficulties in retaining staff and responding to the ageing demographic.

Distance codes

In 2010, under FEMPI legislation, the distance of a patient from a GP's surgery was removed as a factor in calculating capitation fees. The removal of distance codes in calculating certain fees was estimated to have generated full year savings of €5.2m in 2010. While this figure is insignificant in terms of the overall size of the health budget, this cut has had a disproportionate impact on doctors practicing in rural areas. The NAGP calls for distance codes to be reinstated.

Medical graduate debt

A University College Cork (UCC) study found that medical students who graduate with debt are less likely to become GPs, which is contributing to the current critical shortage. Graduate medical students, in particular, struggle to repay loans of up to €100,000 on a basic internship salary of approximately €2,583 gross per month, forcing many to emigrate in search of health services which will provide them with better opportunities to tackle their debts.

The *Irish Medical Journal* highlighted this issue in 2014 and Government representatives made assurances at the time, that the issue would be addressed in the 2015 budget. It is difficult to identify any progress which has been made to alleviate this crisis. Graduate medical students pay approximately €15,000 in fees per year and are not eligible for any State financial aid.

The Government must put in place supports to reduce medical graduate debt. As long as this financial burden exists, the shortage of doctors in general practice will not be addressed. We know that 915 GPs have declared their intention to retire, or emigrate, in the next three to five years. Action must be taken now.

New GMS contract

Ultimately, many of the issues facing GPs will need to be resolved through the negotiation of a new GMS contract. The existing contract was introduced in 1972, and amended in 1989. The scope of general practice

has expanded considerably in the intervening years, and it is clear that the existing GMS contract now fails to encompass the work of many GPs. A new contract has been discussed for the last number of years. The NAGP understands that negotiations on a new contract will take place later in the year, and we welcome confirmation from Minister for Health, Simon Harris, that the NAGP will be a part of the process. However, it is vital that a new contract is negotiated to facilitate the expansion of general practice in order to ensure that we have a properly funded, GP-led primary care service. A new contract should aim to resource GPs in order to ensure that they can manage a range of chronic illnesses. For example, facilitating GPs to manage the treatment of diabetes in the community would free up considerable resources in secondary care.

Incentivise inward investment

GPs, as independent contractors, have traditionally invested in their own practices and infrastructure. This has been good for patients and for the State. However, since the financial crash, this has largely ceased and there is a lack of financial confidence about inward investment. The NAGP urges the Government to explore the use of tax credits as a means of encouraging GPs to invest in their practices. Exploring the use of tax credits and reliefs, we believe, would create more financial certainty and contribute substantially to retaining doctors in Ireland.

9.0 Conclusion

The Healthy Ireland initiative launched by the Government in 2013 states as one of its core principles:

"The principle of equity aims to minimise avoidable disparities in health, as well as the social determinants of health, between groups of people who have varying levels of social advantage. Equity provides all persons with a fair opportunity to attain their full health potential, to the greatest extent possible."[4]

The future of Ireland's general practice remains uncertain, a state in which it has languished for too long. Measures need to be taken to ensure the long-term viability of the profession. The trends of practice closures and GP emigration need to be reversed. Effort must also be made to entice Irish-trained GPs who are working abroad to return to Ireland.

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