NAGP

Cumann Naisiunta na nDochtuiri Teaghlaigh

# PRE-BUDGET SUBMISSION

AUGUST, 2017

TABLE OF CONTENTS

## 1. EXECUTIVE SUMMARY

General Practice is in crisis. The sector is on the brink of collapse and there is an ever-increasing risk to the safety of our patients due to a GMS contract that is out of date, not fit for purpose and placing General Practitioners in unrealistic and unmanageable positions. The current contract, which is more than 40 years old, has become a Frankenstein-like model. In the time since its inception it has been added to and changed without any consideration to the changing needs and landscape of a modern world. All of these parts have created a monster that is cemented in the past and beyond repair.

This document outlines the position of the National Association of General Practitioners (NAGP) in respect of the current state of General Practice in Ireland and a vision for the future of the profession and our patients.

A new GMS contract is now beyond necessity. It is imperative that the process of creating this framework is completed with the highest priority of the government. This process represents an opportunity to re-imagine how general practice, and primary care, is delivered in Ireland. Crucially, it is an opportunity for this to be done collaboratively, to learn from the mistakes of the past and create a framework that works, that meets the needs of patients and retains and engages the general practice talent that is leaving the profession and the country.

Central to our belief of how our system can work is a new common "core" contract for General Practitioners. Extending from this would be a number of options that GPs can select from that are applicable to their specific skillset, their practice and the needs of their patients. For example, this would include contracts for rural and urban deprived areas, group and single-handed practices. We would also see the value in allowing for GPs to take up the option to provide minor surgery or video consultations, among other things.

Preventative healthcare and proactive disease management, with the purpose of optimising outcomes, better quality of life and reversing and controlling chronic diseases to the extent of our technology and ability, should be our common goal. The status quo does not facilitate this though, and therefore, must change.

General Practice and the needs of patients have changed dramatically since the inception of the original GMS contract. As part of a new framework, we need to initiate new structures and flexibility that cater to modern lifestyles and demands on patients, while also recognising the work/life balance requirements of GPs. As the working hours of GPs spiral out of control, we must also address this key issue with a view to patient safety and the quality of care that is delivered.

The NAGP is committed to the creation of a world class GP-Led primary care service that supports ambulatory care in the community, with a focus on frail elderly and other high users of healthcare. We see the potential to reduce the pressure on our hospitals through this primary care service and reduce the number of people on waiting lists and trolleys. We want to contribute to a new contract that will facilitate the retention and engagement of GPs to the extent that they will want to work in the Irish system. We must make it attractive and sustainable for new graduates as much as seasoned professionals. We are committed to the creation of a high-quality, world leading GP workforce. This can only be achieved by working together.

## 2. IRELAND IS BEHIND THE CURVE

The Irish health service is falling behind the rest of the developed world. As of 2016, Ireland ranks 21st of 35 countries in the Euro Health Consumer Index (EHCI), the same ranking that we achieved in 2015. This places Ireland behind countries such as Macedonia, Croatia, Estonia and Slovenia. The United Kingdom places 15th on the index. For a country that claims to be progressive, this is a poor showing amongst our European neighbours.

Irish hospitals are working at near full capacity - 93.8%. This is far above the OECD average of 77.3%. International studies show that the strength of a country's primary care system is directly associated with better patient health outcomes, and this is regardless of per capita health spend and the percentage of elderly in the population. Yet, with our hospitals bursting at the seams and an increasing number of people waiting on trolleys, primary care remains underfunded and underdeveloped in Ireland.

The majority of studies looking at the area of primary care services in comparison to specialist services show that effective use of primary care professionals reduces costs and increases patient satisfaction, with no adverse effects on quality of care or patient outcomes. Yet, we continue to focus on secondary care to the detriment of the entire healthcare delivery system. This will, undoubtedly, see us continue to tumble down the international rankings and put patients at risk.

## 3. PRIMARY CARE – AN INTEGRATED MODEL FOR HEALTHCARE

The key to an integrated, wellness focused healthcare delivery system is Primary Care Resource Centres. This is a different approach to the current Primary Care Centre model and would require the re-designation of the existing and promised centres. However, to truly have an impact in the community, the re-designation to Primary Care Resource Centres is vital.

This new approach would allow the centres to become 'Ambulatory Care Hubs' in the community. The purpose of these Ambulatory Care Hubs is to connect networks of health and social care professionals and facilitate the delivery of an integrated and interdisciplinary healthcare delivery system. Furthermore, it is envisioned that these centres would not necessarily be the locations for a limited number of GP practices and would instead benefit all of the GPs in the communities which are served by the centre. With the inclusion of all of the GPs in the communities, the centres can become a diagnostic and service centre to support the delivery of patient focused care in those communities.

The primary care resource centre model can also support the roll out of essential infrastructure to allow referrals equally through an agreed common pathway. This will bring continuity and standardisation of services at a national level, thus easing the management burden associated with the current system. There is currently disparity across the services.

This is a GP-led model where the GP is the "gatekeeper" to services. There is broad agreement among the stakeholders that GP-led primary care is the fulcrum around which this will be successful. GP-led primary care has the potential to transform healthcare in Ireland and release the pressure on our overburdened secondary care system.

Among the many benefits of primary care resource centres are:

- Puts the patient first
- Changes culture towards engagement
- Solves the impasse on primary care team (PCT) development
- Supports PCT's to deliver on their full potential
- Allows all GPs and health providers to engage with new primary care resource centre buildings
- Allows all GPs and patients equal access to primary care resource centre facilities
- Allows shared governance and development of primary care resource centres
- 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 to reach its potential for more care in the community
- Assist primary care to be more self-sufficient with less reliance on hospitals

This is not a new concept. The approach has been successfully implemented in the UK, the US and Australia. The focus of these implementations has been to ensure that the majority of patient interaction takes place in the community. In the UK, early analysis shows a reduction in emergency department visits, emergency admissions and GP referrals to hospital. In the US, this has resulted in a significant reduction in healthcare spend, better outcomes and higher patient satisfaction. While in Australia, the patients and their care team actively work together in ongoing healthcare management with a focus on high quality healthcare.

We are now calling on the government, in collaboration with the stakeholders, to re-designate the existing and future primary centres to primary care resource centres and to accelerate the roll out of these facilities across the country as a priority.

To bring this system to reality, there are some additional and important elements that will need to be considered. The following sections will outline these and the position of the NAGP.

## 4. STEMMING THE TALENT DRAIN

As we have mentioned here already, there is a crisis in general practice. We are losing GPs. Not just new graduates, but right across the spectrum of the profession. More and more GPs are choosing to emigrate, retire or leave the profession to do something different, because being a GP in Ireland is not an attractive proposition.

The ICGP have reported that only 37.5% of GP trainees are planning a career in Ireland and only 46% of them see themselves as being a full-time GP 5 years on from graduation. This is a startling and worrying figure. When we consider a report in the Irish Independent in July 2017 that has quoted that there are currently 666 GPs over the age of 60 with an average retirement age of 67. The Irish Medical Times reported, also in July 2017, that in excess of 10% of GMS GPs are expected to retire in the next 2 years. If the current trend with new graduates continues, if we continue to lose GP graduates, we will soon be in a crisis that may well be irreversible.

The pressure is already showing with many rural practices closing, struggling to find replacement GPs and locums.

It is now beyond critical that this situation is addressed in a meaningful way. As long as general practice remains an unattractive proposition we will lose talent to other countries, retirement and attrition. We believe that a GP-led primary care model, as outlined, combined with a new GMS contract to support this will help us to retain talent in the profession in Ireland and therefore this must become the highest priority.

To enhance the attractiveness of general practice the NAGP would encourage and support the following:

- A properly funded GMS contract will improve morale and the financial base of general practice. As a start, the reversal of FEMPI legislation will go a long way;
- Improved incentives and support for newly qualified GPs to encourage them to stay in Ireland;
- The introduction of start-up grants and a rent support scheme with funding linked to areas of deprivation scores;
- Financial supports for HIQA compliance as these are considerable costs

Ireland must compete to retain and attract back our GPs. The first step must be to stabilise general practice as a profession and make it an attractive career choice. A new GMS contract is an opportunity to address this.

## 5. CHRONIC DISEASE MANAGEMENT

Two out of five hospitalisations occur, indirectly or directly, because of chronic illness such as chronic lung disease, heart disease or diabetes. By 2020, 40% of the Irish population will have one or more of these chronic diseases.

An adequately resourced primary care system can deliver properly structured treatment protocols to ensure more chronic disease patients remain out of hospitals for longer. However, a programme of chronic disease

management in the community will require that the necessary infrastructure, resources and staffing are in place. The primary care model of managing disease in the community would relieve pressure on emergency departments in the long term and lead to a more cost-effective health system.

The change in managing chronic disease from the hospital setting to primary care will not happen overnight. The primary care infrastructure will need to have a strong GP interface with secondary care and communities and this will require a structured integration between primary and secondary care, including IT systems. We believe that this will require a 5-year transition programme that can be rolled out on a phased basis with voluntary GP participation.

This new approach to chronic disease management does not mean that we believe that patients in crisis should not be referred to a hospital. It does mean that patients who do not need to go to hospital can receive the treatment that they need in a community setting.

The NAGP will seek to work with the Irish College of General Practitioners which has extensively developed evidence and pathways for chronic disease management in many of the key areas.

## 6. STC'S IN PRIMARY CARE

Patients in Ireland are having to attend emergency departments across the country to have procedures that could have been carried in the community by their GP. Due to the drastic cuts in General Practice funding over the past number of years, in many cases GPs would be putting themselves in a financially unsustainable position by offering these procedures and are left with no choice but to refer the patient to the emergency department. This is not what GPs want.

The current list of special type consultations (STC) is unworkable and does not allow for the scope or funding in the modern general practice. The NAGP want to work with the department of health to create a new list of STC's that more accurately reflects modern general practice and provide the flexibility required to move with the changing requirements of their patients. This list of properly funded STC's will bring a reduction in ED waiting times and take further pressure from hospitals.

The NAGP proposes that each item on the new list will need to take account of several key elements:

- GP time involved
- Expertise required
- Indemnity cover for the specific task
- Interpretation of results
- Required overheads, ie staff, equipment, consumables, maintenance

In addition, funding will need to be provided for the continuing professional development necessary to meet the needs of patients with upskilling and retraining for the provision of these STC's.

## 7. OUT OF HOURS SERVICES

The current structure of the out of hours services is placing unrealistic and unsustainable demands on GPs and placing patients at risk. However, we acknowledge that this service is crucial to the people of Ireland and must be maintained. In fact, it is our belief, that out of hours GP services must protected, developed and become part of a primary care service that is integrated with day-time practice. This can only be done with a GP-led service.

Currently, out of hours GP care is provided by small town rotas, commercial deputising services and GP co-ops. It is the view of the NAGP that GP-led co-ops is the best model for the delivery of this service. We see the need for these co-ops to be developed and made available nationally for the benefit of patients.

The current contract requires 24/7 availability of GPs in addition to the provision of 40 hours routine availability. This is an onerous obligation and must change. Even outside of the contractual obligations though the current model will not work for much longer for three reasons:

1) The demographic of existing GPs is now too old to continue with this burden of work

2) It is not a structure that newly qualified GPs are willing to work in and they can work in far more favourable conditions in other countries

3) An older and more complex patient demographic is placing hugely increased demands on GP's. It is unreasonable to expect that they will undertake compulsory out of hours work in the evenings, nights and weekends after a stressful week in their surgery.

The NAGP is now proposing a number of solutions to the out of hours service problem. These are necessary to create a viable out of hours service and to stabilise daytime general practice.

- A commitment to the removal of compulsory out of hours working for GP's
- A separate contract and budget for out of hours
- A commitment to a GP managed co-op model
- A clear pension structure for GPs that choose to work solely out of hours
- Upskilling of other healthcare staff to deal with less complex cases under the supervision of GPs
- The introduction of new consultation models such as telemedicine to drive greater efficiencies in the service

## 8. GENERAL PRACTICE IS GROSSLY UNDERFUNDED

In Ireland, the healthcare budget allows for approximately 7/8% in primary care and of that spend only 3.5% of the budget is allocated to providing GP services. When we compare this internationally in countries who have well developed primary care systems such as Australia, New Zealand, Denmark and Canada we fall well behind that standard.

If as proposed by the Slaintecare report we are to make the decisive shift from secondary to primary care and, as the government and HSE has stated, then funding must also move. This shift of funding is essential.

This reduction of funding over the last 10 years has put GPs under serious financial pressure to the point where many practices have become unviable. If we are to move to a GP-led primary care service then it is imperative that the funding commitment that has been promised is realised.

## 9. THE RURAL GP

The rural GPs of Ireland have suffered significantly because of the removal of distance band codes, rural practice grants and other FEMPI cuts. The talent retention problem is resulting in many rural GMS posts remaining unfilled for years in some cases, practices closing due to succession issues, and GPs burning out due to lack of locum cover. Morale is at an all-time low among the rural GP community.

While the NAGP welcomes the Rural Practice Support Framework, there is more required from the government to ensure that rural practices can survive.

We are proposing that the following be implemented as part of a new GMS contract:

- An option for rural GPs and their staff to take employee status
- Properly funded out of hours cover, sick leave and holiday relief as rural practices are more likely to be run by single handed GPs
- The introduction of rural practice weighting to the capitation fee to allow for pensions to be comparable to urban GPs

## 10. THE URBAN DEPRIVED GP

GPs operating in urban deprived areas are presented with a specific set of challenges that are not adequately addressed by the current GMS contract. In these areas, the GP is working with a far greater proportion of GMS patients and the current provisions in the GMS contract do not meet the needs of these GPs to allow for a viable practice. In addition to a greater proportion of GMS clients, there is also the effect of an ageing population which has a greater impact in an area of deprivation.

## 11. PRACTICE NURSES

Practice nurses, as well as other professionals, are an invaluable part of the GP practice team that reduce the burden on GPs. We note that the government has recently committed to providing an additional 900 community health nurses nationally. However, the NAGP feels that these resources would have been better utilised in a practice nurse capacity. By deploying these resources in the capacity of practice nurses, the GPs are better resourced to care for patients in the community.

To further assist GPs and practice nurses, the training of healthcare assistants or physician assistants to carry out minor tasks would also alleviate workload pressure and is an option that must be explored.

## 12. CONCLUSION

General practice in Ireland is in crisis, but we have an opportunity to create something that is the envy of many of the developed nations of the world. We have the opportunity to build a primary care service that treats patients in the community, that leads to better outcomes and patient satisfaction, that releases the pressure on our overburdened hospitals and attracts and retains our brightest talent to stay in Ireland.

Crucially, though, we must act. We must accelerate the process of negotiating a new GMS contract, we must act on the primary care resource centres designation and we must do this as the highest priority, now.

The NAGP is committed to working in collaboration with the stakeholders to bring this vision for healthcare to reality.

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