IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Submission to the Oireachtas Health Committee on

General Practice Manpower and Capacity Issues

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Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
Tel (01) 676 72 73
Email: vhetherington@imo.ie
Website www.imo.ie

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GP care is the cornerstone of any universal healthcare system. Continuity of care and the patient-centred approach that is specific to General Practice is associated with better health outcomes, equity of access, reduced inequalities in health, more appropriate utilisation of services and long-term cost effectiveness[1] [2] [3]. Up to 90% of consultations are treated in General Practice without further referral to secondary hospital care.[4]

Extensive research by the late Barbara Starfield[5] found that:

- Increasing the supply of GPs is associated with better health outcomes, lower rates of all-cause mortality, lower post-neonatal mortality rates, lower mortality rates from stroke, lower numbers of people reporting fair to poor health and higher life expectancy;
- Evidence in both cross-national and within national studies show that access to GP care is associated with more equitable distribution of health in populations;
- The continuity of care provided by General Practice is patient-focused rather than disease-focused and is associated with a decreased likelihood of future hospitalization, as well as decreased emergency department use;
- Good patient-physician continuity is also associated with time saving, less use of laboratory tests, fewer referrals to secondary care and lower health care expenditure. [6]

International research into healthcare systems from Starfield[7] to Kringos et al[8], firmly relates to the unique role of the General Practitioner in terms of continuity and coordination of care and the resources provided to support GP care. Countries that are considered to have a strong primary care systems exhibit the following traits:

- Universal access to GP care with little to no out-of-pocket payments;
- Provide appropriate economic conditions and distribute resources equitably based on medical need;
- Have strong governance arrangements in place including compulsory registration with a GP and a GP gatekeeping role;
- Provide a comprehensive range of services in General Practice and the community;
- invest in the development of the workforce.

Despite the known benefits of GP led care in the community, General Practice in Ireland has been decimated with the removal of €160 million or approximately 38% of funding through the heavy

[1] Starfield B. Shi L and Macinko J, Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502)
[2] Atun R, What are the Advantages and Disadvantages of Restructuring a Health System to be More Focused on Primary Care Services? Copenhagen, WHO Regional Office for Europe, Health Evidence Network report ; January 2004
[3] Kringos DS et al, The Strength of Primary Care in Europe, NIVEL 2012
[4] Gouda P. 2013 Treat or Refer? Factors Affecting GP Decisions Forum August 2013
[5] Starfield B, Shi L and Mackinko J. Contribution of Primary Care to Health Systems and Health, The Millbank Quarterly, 2005: 83:3 457-502
[6] Starfield B, Shi L and Mackinko J. 2005
[7] Starfield B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012
[8] Kringos DS et al, The Strength of Primary Care in Europe, NIVEL 2012

handed and arbitrary FEMPI mechanism. Ireland is facing a shortage of GPs as the current GP population is aging and our newly trained GPs see emigration as the only viable option. Countries that are considered to have a strong GP and community care system spend up to 10% of the overall health expenditure on General Practice with a further 10% spend on allied community health and social services. [9] Currently the Government spend on General Practice amounts to just 3 % of overall health expenditure. [10]

With Ireland's ageing population and the growing incidence of chronic disease, investment in GP care will improve outcomes for patients and reduce future hospitalisations. Investment in General Practice will not solve the crisis in our Emergency Department but it will reduce the rate of increase in demand on the hospital system in the medium to long-term.

A New Strategy for the Development of General Practice over the Next Ten Years

In the IMO submission to the Cross-Party Committee on the Future of Healthcare the IMO is calling on the Department of Health and the HSE to agree a strategy with the IMO for the development of General Practice in Ireland. To ensure the maximum benefit for both patients and the health system the Strategy must include:

A GP Manpower Action Plan

Approximately 17% of GPs are over 60 years old[11] and reaching retirement age, while 17% of newly qualified GPs work abroad[12] with many more planning to emigrate. Based on current retirement and emigration rates, the HSE estimate that by 2025 an additional 1380 GPs are required to ensure the provision of GP services to the under 6 year olds and over 70 year olds – to expand GP care to the entire population an additional 2,055 GPs are required by 2025.[13] A manpower action plan should include an assessment of practice staff needs including practice nurses, managers and other support staff.

Proposals to address the shortage of GPs by transferring GP tasks to other healthcare professionals is not in the interest of patients or the state. In addition to interrupting continuity of care, nurse delivered care is associated with a greater use of healthcare resources[14] including higher number of visits[15], longer consultations[16] and higher use of diagnostics[17] while commercial factors have been

[9] Nivel, Country information on Primary Care, See http://www.nivel.nl/en/dossier/country-information-primary-care

[10] CSO, System of Health Accounts 2014

[11] Collins C and O'Riordan M, The Future of Irish general Practice: ICGP Member Survey 2015, ICGP Nov 2015

[12] Collins C. et al, Planning for the Future Irish General Practitioner Workforce – informed by a national survey of GP Trainees and Recent GP Graduates. ICGP 2014

[13] HSE HR Directorate National Doctor Training and Planning, Medical Workforce Planning Future Demand for General Practitioners 2015-2025, HSE: Sept 2015

[14] A. Hemani *et al.*, 'A Comparison of Resource Utilization in Nurse Practitioners and Physicians', *Effective Clinical Practice*, Vol. 2, No. 6, November 1999, pp. 258-265.

[15] E.R. Lenz et al., 'Primary care outcomes in patients treated by nurse practitioners or physicians: two-year follow-up', Medical Care Research and Review, Vol. 61, No. 3, September 2004, pp. 332-351.

[16] C. Seale, E. Anderson, and P. Kinnersley,, 'Comparison of GP and nurse practitioner consultations: an observational study', *British Journal of General Practice*, Vol. 55, No. 521, December 2005, pp. 938-943.

found to influence pharmacy prescribing above clinical evidence. [18] There is no evidence that patient outcomes are improved by transferring tasks to other healthcare professionals in the community and no research has measured the potential impact on health outcomes caused by the further fragmentation of care.

A New 21st Century GP Contract

In order to halt the exodus of newly qualified GPs, priority must be given to negotiating a new GP contract with the IMO that is properly resourced and fit for purpose for a 21st Century Health Service to include:

- Terms and conditions that ensure both existing and newly qualified GPs are attracted to a career in the health service. 17% of newly qualified GPs work abroad[19] with many more planning to emigrate to countries where GP care is more appropriately valued.
- A working environment including an out-of-hours service that provides vital continuity of care and respects the needs of individual GPs
- Investment in evidence-based Chronic Disease Management Programmes (which newly qualified GPs are trained to deliver) and opt-in enhanced services (many GPs have training in other specialist areas such as minor surgery or dermatology)
- Allowances for the employment of practice staff (including medical, nursing and practice support staff)
- Additional supports that address the real and specific needs of patients in both rural and deprived areas. While practice allowances for rural General Practice have recently been restored, additional resources have yet to be provided for practices in urban deprived areas to take into account higher mortality and morbidity rates.
- Appropriate adoption of new work practices such as telemedicine that are based on international best practice and assure continuity of care

Incentives for Investment and Development of Infrastructure

Incentives must be provided for the development of infrastructure including premises, medical equipment, diagnostic equipment, IT (as per the recommendations in the Indecon report) [20]

While there are supports in place for practices the vast majority of the developments in General Practice, be they through services or facilities have been as a result of General Practitioners taking investing and taking the risk upon themselves and their practices to make improvements. Indecon carried out an analysis of potential measures to encourage the provision of primary care facilities and recommended a multi-faceted approach involving HSE-leased or built premises, GP-led centres

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[17] K. Rosenberg, 'NPs and Physician Assistants Order more Imaging Tests than Primary Care Physicians', *American Journal of Nursing*, Vol. 115, No. 3, March 2015, p. 63.

[18] P. P. C. Chiang, 'Do pharmacy staff recommend evidenced-based smoking cessation products? A pseudo patron study', *Journal of Clinical Pharmacy and Therapeutics*, Vol. 31, Issue 3, June 2006, pp. 205–209; P. Rutter and E. Wadesango, 'Does evidence drive pharmacist over-the-counter product recommendations?', *Journal of Evaluation in Clinical Practice*, Vol. 20, Issue 4, August 2014, pp. 425–428.

[19] Collins C. et al, Planning for the Future Irish General Practitioner Workforce – informed by a national survey of GP Trainees and Recent GP Graduates. ICGP 2014

[20] Indecon International Economic Consultants 2015 Analysis of Potential Measures to Encourage the Provision of Primary Care Facilities , Dublin 2015

and incentives for GPs to invest in premises and equipment. Targeted incentives would ensure the development of facilities would be GP-led and could significantly reduce exchequer costs and enhance health outcomes. The report also recommended that when developing HSE centres that the HSE should consult with GPs and consider existing and planned GP investments.

Access to diagnostics and allied health and social care professionals in the community

With just 13 public MRI units and 17 public CT scanners per million population, access to diagnostics is a major issue. [21] While access is readily available in the private system approximately 90% of GPs have no direct access to MRI Scans and 70-80% have no direct access to CT Scans in the public system. [22]Where public access is available long waiting lists apply. Appropriate provision of diagnostics in the community will reduce referrals to outpatient care.

Waiting lists also apply for access to all community health and social services for GMS patients and many of these services are simply not available for those without a medical card. Integrated manpower planning must include an assessment of the number of allied community health and social care professionals needed to meet population need. Rules relating to access to services must be developed and consistently applied.

A commitment to preserving the positive traits of General Practice:

A community-based, same-day appointment service where possible – Currently GPs provide a same day service 24/7, 365 days a year. Expanding free GP care to the entire population will increase GP utilisation.[23] Behan et al have estimated that expanding access to GP care to the entire population could on average increase GP consultations by 23% (or4.4million), a view that is consistent with predictions by the Expert Group on Resource Allocation and Financing in the Health Sector[24] who estimated that GP utilisation would be 19-25% higher if the utilisation were determined by healthcare need alone. Preserving the same ratio of GPs to population will lead to waiting times of up to a week as experienced in the UK's NHS. [25]

The GP independent contractor model - The independent contractor model provides patient focused, quality of care, equity of access and value for money[26] and is the model

[21] OECD Health Statistics 2015 [downloaded from http://www.oecd.org/els/health-systems/health-data.htm]
[22] O'Riordan M. Collins C. Doran G. Access to diagnostics: A key enabler for a primary care led health service, Irish College of General Practitioners (ICGP), Dublin 2013
[23] Brick A, Nolan A, O'Reilly J and Smith S, Resource Allocation Financing and Sustainability in Health Care - Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, ESRI, Dublin: 2010 Vol II , p507
[24] Brick A, Nolan A, O'Reilly J and Smith S, Resource Allocation Financing and Sustainability in Health Care - Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, ESRI, Dublin: 2010 Vol II , p507
[25] Campbell D. Patients' waiting times on NHS 'a national disgrace' – GP leader, The Guardian 26 September 2014 (https://www.theguardian.com/society/2014/sep/26/patients-waiting-times-nhs-gps-uk accessed 02 August 2016)

[26] IMO Submission to Department of Health Public on the Scope of Private Health Insurance to incorporate additional Primary Care Services. IMO: January 2015

used in most developed health systems. [27] While there may be an argument for salaried GPs in certain instances where the HSE is unable to fill a GMS post, however, in the long-term the independent contractor model is more likely to support productivity, innovation and continuity of care.

Corporate models of Primary Care have also been proposed as a solution to that offers short-term advantages in terms of ready investment capital, however in the long-term, the corporate model of care is profit-focused not patient-focused, can disrupt continuity of care and can increase supplier induced demand.

The GP gate keeper role. The GP guardian or gatekeeper role whereby GPs guide patients through the health system to the most appropriate care is effective and reducing overall costs and prevents overuse of diagnostics and expensive hospital services.

Access to GP care should be expanded on a phased basis taking into account income and medical need. - Increasing capacity in General Practice will not take place overnight. Because those in the middle income bracket above the threshold for a medical card are most likely to be deterred from visiting their GP due to out-of-pocket costs, access should be expanded on the basis of income not age cohort.

Provision of Appropriate Resources.

Investment in GP care will reap long-term benefits. GP services must be adequately costed and appropriate resources provided.

[27] Ed. E Mossialos and M. Wenzl, London School of Economics and Political Science, R Osborn and D, Sarnak, 2015 International Profiles of Health Care Systems, The Commonwealth Fund. The Commonwealth Fund January 2016