IMO Submission on the Review of the Operation of Cuts under the Financial Emergency Measures in the Public Interest Act 2009

as covered by

S.I. No. 638/2010 — Health Professionals (Reduction of Payments to General Practitioners) Regulations 2010

4 January 2013

Executive Summary

1. General Practice is at breaking point and the imposition of further cuts – on top of recent severe cuts in the level of financial support for GP services – threatens to destroy the fabric of the Irish General Practice system.

2. Decisions taken today may well herald the introduction of waiting lists for GPs for the first time in Ireland and the unavailability of GP services in certain parts of the country. Indeed some of these effects are already being seen with increased attendance at GP out of hours services.

3. Further cuts in payments to GPs will mark the end of any capacity to introduce Universal GP Care in Ireland in the foreseeable future.

4. In undertaking the Consultation Process under the terms of Section 9 the Financial Emergency Measures in the Public Interest Act 2009 (FEMPI), the Department of Health must have consideration for:

    - The cumulative impact of various cuts in payments to GPs already introduced in 2010 and 2011 and 2012.

    - The inability of GPs to continue to cross subsidise GMS Patients as a result of falling incomes from private patients.

    - The downstream impact on overall secondary care health costs caused by the imposition of further cuts on primary care service providers. This is being seen already in respect of an increase in the rate of referrals to secondary care centres.

    - The increasing demands being placed on GPs as a result of the recession and the increased incidence of recession related illness.

    - The relative inflexibility of the GP cost base where fixed costs account for a dominant proportion of the costs of a typical General Practice Surgery. Recognition of the inflexibility of these costs occurs in the UK where targeted specific funding for most of General Practise infrastructure and cost base occurs. It is accepted in the UK / NHS that the cost basis is at the level of an average of 63% turnover and funded accordingly. This is National Published data. This figure has relevance to the GMS GP service as patient profiles are similar to the UK population. Not giving due recognition to these fixed costs will endanger the continued success of the GMS GP service.

Submission

The Minister for Health, in accordance with Section 9 of the Financial Emergency Measures in the Public Interest Act 2009, (FEMPI) has initiated a full review of payments to GPs.

The IMO wish to make a submission under FEMPI Consultation process. It is clear that cuts in the order of €70 million are being contemplated – which are in addition to the previous cuts in recent years. Cuts of this nature will devastate general practice and will, in turn, have adverse effects on the most vulnerable patients who are dependent on the services of their GP.

This IMO submission gives a view of general practice, the patients treated, and the services provided. This provides an account of the impact of previous FEMPI cuts on general practice generally and of rural and disadvantaged areas in particular. It concludes that it is vital that no further cuts are imposed on GP front line services as the very fabric of our general practice service is now under threat.

It is clear from the work done by the IMO that unless general practice is protected waiting lists are inevitable. General Practice will lose the capacity to meet the needs of patients and this will lead to significantly increased referrals to other services which are already under pressure.

In the longer term further cuts at this point will do irreparable damage to our hopes of being able to provide cost effective chronic care management and will virtually guarantee that universal GP care will not be possible for at least 5 years.

This submission will also argue that these cuts are not necessary. There is another way to meet the strict budgetary limits imposed by the State's funders in a proportionate and fair manner. The challenge is to look at new and innovative ways of maximising our resources and using them in a way that meets patient needs and provides greater value for money. The IMO has considered these issues and believes it can help to achieve these aims.

1. Background

At present GPs are contracted by an agreement in the 1989 contract to provide general medical services to eligible patients. Participating GPs currently provide these services to 1.83M of the population. The contract is demand led and while it facilitates the immediate needs of patients it does not adequately provide for the early detection and prevention of disease. The way the contract is set out provides for the provision of what might be termed traditional GP services and ignores the huge evolution of GP services internationally (and nationally) over the past two decades.

Patients currently qualify for state funded treatment based on income either as a full GMS patient or if they qualify for a GP Visit Card (131,193 patients). Patients qualify for eligibility predominantly on the basis of their financial circumstances and consequently represent the most disadvantaged of society.

The model of care under the existing GMS contract has evolved over time but it has not kept pace with developments in modern general practice.

An attempt has been made to provide for certain services under the contract by means of special arrangements for the delivery of items of special service. These items facilitate the delivery of 18 services including cryotherapy, suturing of cuts, draining of hydroceles, treatment and plugging of dental and nasal haemorrhages, recognised vein treatment, ECG tests and their interpretation, instruction in the fitting of a diaphragm removal of foreign bodies from the conjunctival surface of the eye, removal of certain foreign bodies from the Ear Nose and Throat, nebuliser treatment, bladder catheterisation, other family planning and some vaccines.

However these are not sufficient in their own right and therefore (to meet the medical needs of patients) some GPs have supplemented the contractual services provided to patients, often on a pro bono basis. It is a common feature of practice that GPs have used the overall income of their practice to provide services to patients based on their medical need and without regard to the cost of providing each service.

Over time this has enhanced the service to patients and has alleviated the pressure on the hospital system.

However this situation is no longer sustainable.

To date despite reduced incomes (from both public and private sources) GPs have often tried to provide additional services not provided for in the contract to medical card patients on a pro bono basis, but their ability to do so where further cuts are anticipated is likely to be heavily curtailed.

An example of how GPs are being forced to cut back can be seen in the example of Nursing Homes and Patients. Many GPs report a large number of patients in nursing homes to whom they have provided service. Service to these and other patients who are house bound requires house calls. However, the reality is that reduced resources along with the time consuming nature of this calls has made the provision of these services beyond the capacity of practices. Deterioration in this valuable service has been reported and is likely to continue and exacerbate the current situation further.

2. Service Demands

The level of demand for GMS services has increased significantly with an increase of 27% from 2009 to 2012; an increase of 389,862 additional patients. In addition the demand for GP visit card increased in the same time period by 39%; an increase 36,812. Providing service for this number of patients poses significant challenges for GPs. A significant implication of this development is the increased demand for patient consultations as illustrated. CSO has indicated that the average visiting rate for a GMS patient is 5.2 times per year against 1.9 times for the patient who does not have insurance. The 2011 OECD figures clearly recognise that CSO data underestimates GP workload. A recent study of

multiple GP records confirm that the CSO data under reports the GP attendance rate by factor of 30% with the true attendance rate unsurprisingly being similar to UK rates.

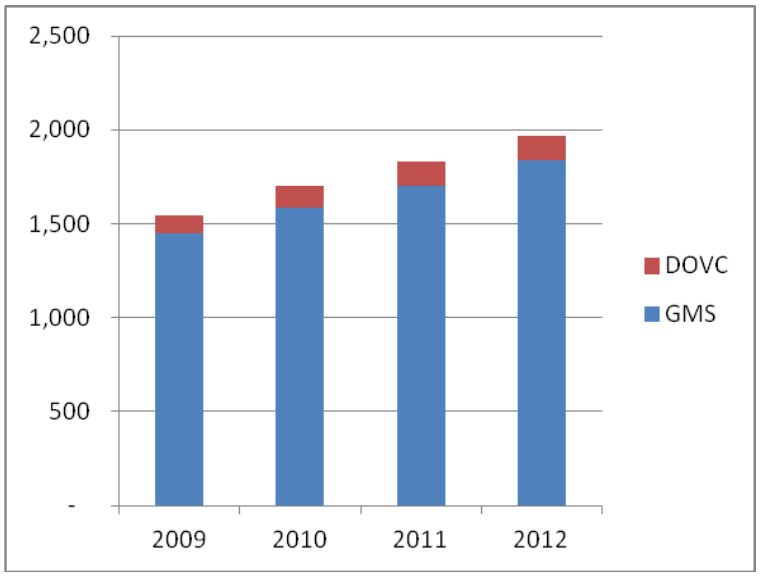


Figure 1: Number of Eligible Patients Covered

Moreover GPs report an ever growing number of private patients presenting with a greater range of increased stress based illness which is often recession based. Patients are increasingly taking more time with their doctor which averages at an additional 12 minutes per consultation. GPs have indicated that 92% of these patients show signs of increased co morbidities and are frequently delaying visits to their doctor. This is likely to have the effect of delaying the timing of intervention with a consequent increase in complexity of treatment which will inevitably be provided at far greater cost.

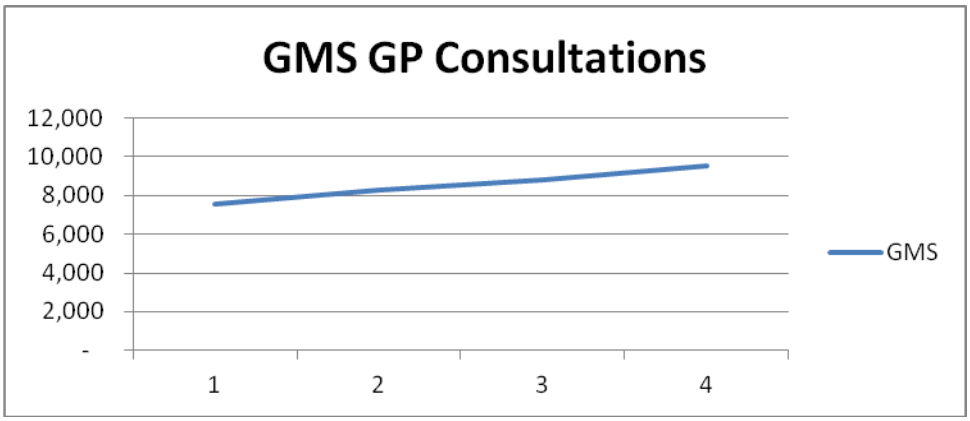


Figure 2: Number of GMS Consultation

Coyle E, et al[1] have established in their study of referral patterns in Irish general practice that 90% of cases were dealt with directly by the GP where 6.9% of referrals were referred elsewhere including the secondary hospital setting. This role as the first point of call for most patients as well as the role of gatekeeper to other services is a vital function of general practice which must be protected if the health system is to be sustained into the future.

The demands from general practice, both from patient expectations and from medics initiated in the hospital system have increased dramatically in recent times. This has the effect of increasing the burden of service on general practice. These have included;

▪ Blood tests arising from hospitals in the management of chronic illness i.e. Diabetes, Inflammatory Bowel Disease, Warfarin Management and Oncology	▪ Patient-led requests for blood tests as part of routine screening
▪ Blood tests that arise as a result of pre-OPD, pre-admission and post-discharge hospital protocols	▪ Chronic Disease management
▪ Women's and Men's Health Clinic Visits	▪ 24 Hour Blood Pressure Monitoring

[1] Ir J Med Sci. 2011 Dec;180(4):845-9. doi: 10.1007/s11845-011-0724-2. Epub 2011 Jun 12.

3. Costs of providing the service

Unlike arrangements in comparable countries GPs are required to cover costs of their practice and have reported overheads of 60% of turnover. The main elements of costs are:

Staff Costs	Difficult to reduce costs without reducing both medical and administration hours. A large number of GPs have reduced hours Availability of locums is a problem making flexibility difficult and impacting on service provision.
Energy Costs	The costs of Lighting and Heating for general practice have increased The recent announcement of further increases in energy costs particularly electricity is putting additional pressure on general practice
ICT Costs,	General Practice has developed good IT systems which facilitates the large volumes of patients seen. These costs are still incurred by GPs
Rent/Interest, Rates	The costs of providing a premises with upwards only rent reviews as well as the cost of rates is a significant overhead which cannot be reduced
Insurance / indemnity costs,	These costs have increased in 2012
Transport costs	The cost of running a car in Ireland is significant. The cost of a GP home visits is not economical to provide at current fee levels
Pension	The demographic profile of general practice has a significant challenge for pension provision. The introduction of the pensions levy, the application of the universal social charge and PRSI, and the changes announced in the budget will have an impact on pension provision which poses a significant challenge.
Building maintenance	GP must maintain premises at cost to provide suitable premises for their patients. Increasing numbers of patient visits increases wear and tear

An increase in visits to GPs involves a rise in practice costs in addition to the natural cost increases. In addition the requirement for extra services is evident with an ever increasing number of forms to be signed for clients who require letters from their GP in order to receive benefits.

The data provided by Dept. of Health to OECD indicates that the average Irish GP is allocated less than 40,000 euro for practise expense. This is in contrast to the provision of 140,000 sterling by the NHS for non dispensing GPs, or if including dispensing GPS, averaging 162,500 sterling. In the UK there is a distinct similarity with the infrastructure in Ireland. The NHS "GP Earnings and Expenses 2010/11" report, published on 26 September 2012, states on page 5 that the Expenses to Earnings Ratio (EER) for UK GPs was *"60.9% (an increase of 1.2% since 2009/10)"*[2]. It should be noted that this

[2] The full report can be accessed at https://catalogue.ic.nhs.uk/publications/primary-care/general-practice/gp-earn-expe-2010-2011/gp-earn-expe-2010-2011-rep.pdf

figure excludes financial provision for IT, Hardware and Software for NHS GPs, which is wholly funded from a separate budget. Including these overheads, which GMS GPs have to finance, increases the EER to approximately 64%.

As previously indicated there is a similarity between the Irish and UK patient attendance rate and of the infrastructure required to support delivery of the service to patients.

4. The effects of previous cuts

The previous round of cuts applied in a structured way had a detrimental effect on patient services with knock on impact on the most vulnerable patients who depend on their GP. The impact of these changes has been significant on those who need the service most. This has been highlighted previously by the IMO in previous submissions and is summarised;

The IMO conducted a consultation process with GP members to establish what impact previous cuts had on their service and to determine what action they are likely to take if the proposal to cut fees is applied. In dealing with the effects of reduced income 54% of GPs have reduced staff hours with the effect that 60% had to reduce the range of services to patients and 70% of GPs have reported they have ceased providing 'pro bono' services.

Reduction in fees to over 70 in nursing homes	The increasingly early discharge of patients from hospitals, needing more complex care in a nursing home setting has increased the workload. Moreover the additional requirements to monitor and report on medications as well as the ever increasing level of paperwork has put this service under pressure. The 54% reduction in the payment for this service is both severe and disproportionate and has put the viability of providing this service in question. 47% of GPs have now suggested that they are not likely to register a patient in a nursing home.
Distance from surgery capitation fees	Using age, gender and distance for fees was designed to ensure that those patients listed in the various categories would receive the optimum care and attention during visits to the General Practitioners. The impact of these cuts has been disproportionate to rural areas which has put rural practices, already under pressure, in an already very difficult situation. The reduction has ranged from 0.87% in Dublin practices to Roscommon which experienced reductions of 5.8%
Distance from surgery out of hours fees	The provision of out of hours services is a crucial element of health service provision particularly in rural Ireland. In locations where the distance to the nearest hospital is significant the provision of an out of hours service is vital. It is clear that the removal of this provision has had a detrimental effect on rural practices and reduced resources to a degree that the provision of these services is greatly curtailed. The range of reduction in income in this area in Dublin was 6.79%, compared to Cavan which experienced reductions of 36.2%. The IMO concern is that it has become increasingly economically unviable to fund non surgery consultations. In this context the attraction of rural practise will continue to wane as it has in deprivation areas. Rural areas will suffer a loss of many GPs and replacements will become unavailable. It appears that Department

	policy is to promote a policy of making it unattractive to work in rural settings to favour work in larger community settings. Out of hours service provision is at a crossroads with many GPS giving serious consideration to reverting to small rotas due to the unaffordable expense of some coops. The co-operative movement has been albeit a delayed success with the initial absence of seed funding from the Dept. of Health. It is of concern on health and safety grounds that due to financial restrictions that GPs may again revert to longer out of hours provision to make up the shortfall in expense provision by working longer hours in smaller rotas. This will have the knock on effect of collapsing the Coop system and stretching an already overburdened ageing GP workforce.
New rates for out of hours visits	The new rates that apply for payment of out of hours visits has reduced the level of income to critically low levels and mean that it is no longer economically sustainable to provide this service on an on-going basis. The overall reduction in resources results in a difficulty in maintaining existing services to patients. The level of out of hours services will inevitably be curtailed resulting in less access for patients and more pressure on other services.
Distance from surgery for temporary residents	The effect of this cut is to reduce the overall level of income to general practice with the consequent reduction in capacity for general practice to provide the same level of service. This results in a lack of service for patients who may have serious needs and who then are delayed visiting their own doctor or revert to other services which can be less accessible to patients and incur greater cost for health care.
Fund of general practice 1/93	The removal of this mechanism for funding general practice has - in tandem with the other cuts - affected the funding of this service. 99% of GPs believe that the viability of providing a full range of services in General Practice is under threat with a knock on impact for patient care and increased demand for other services.
Reduction in practice nurse manager	The detrimental effect of these cuts in reducing staff levels has significantly reduced the capacity of general practice to provide the optimum level of service. The effect of this has been to reduce the amount of service provided to patients. Additionally it has the effect of a greater level of illness which must be treated in other settings at significantly greater cost to the state.
Special items of service	The reductions applied to carrying out such procedure as Suturing, Removal of cysts, and ECG tests is a false economy which has the effect of reducing the level of provision of this service in general practice as patients are referred elsewhere for these services. Invariably patients will increasingly turn up at emergency departments putting this service under impossible strain at considerable inconvenience to patients and at multiples of the cost of providing this service within general practice. The consequent deskilling of GPs in this area which will in turn have a negative impact on overall ability of the General Practitioner to sustain these activities.
Maternity and infant scheme	This cost effective scheme provides for an initial examination by the GP with a further 6 examinations during the pregnancy, which are alternated with

	visits to the maternity unit/hospital. Patients who have a significant illness, e.g. diabetes or hypertension, you may have up to 5 additional visits to the GP after the birth, the GP will examine the baby at 2 weeks and both mother and baby at 6 weeks. There is a need to consider: • The Mother and Infant Care Scheme was negotiated at specially reduced professional rates in order to maximise efficiency and value for money; • Despite this, fees and allowances have already been reduced by 8% in 2009 in line with other cuts introduced under FEMPI; • Due to the further reduction of 8% and given the uniquely low rates paid for this scheme, there is a real risk of GPs leaving the public scheme with serious consequences and significantly increased costs in the hospital setting.

While the rise in overheads has increased the existing cost base, as practices work to provide the same level of service, the income amount which covers the costs has significantly dropped. This is impacting on the viability of general practice in many locations. When the GMS reductions of 16.5% under the FEMPI process are combined with the effect of the significant reduction in private income the impact has been stark and the sustainability of the existing GP model is under threat.

To date the combined income has been used to provide the service to all patients where the outstanding characteristic of general practice has been the equality of care for both public and private patients. 92% of GPs have indicated that their private income has reduced with 36% of GPs stating the reduction was between 30-40%.

The impact of the reduction in income has been severe and while many practices have indicated they managed to maintain a significant level of service it has been a struggle for the overwhelming number of them. Despite reports to the contrary (WHO) general practices report themselves to be at full capacity in providing the existing range of limited service. Practices report difficulty in managing their cash flow at a time when gaining access to cash from the banks is difficult. The strains of maintaining service at this level and meeting the needs of patients is beginning to show with staff being frustrated and many GPs indicate the level of stress is significant.

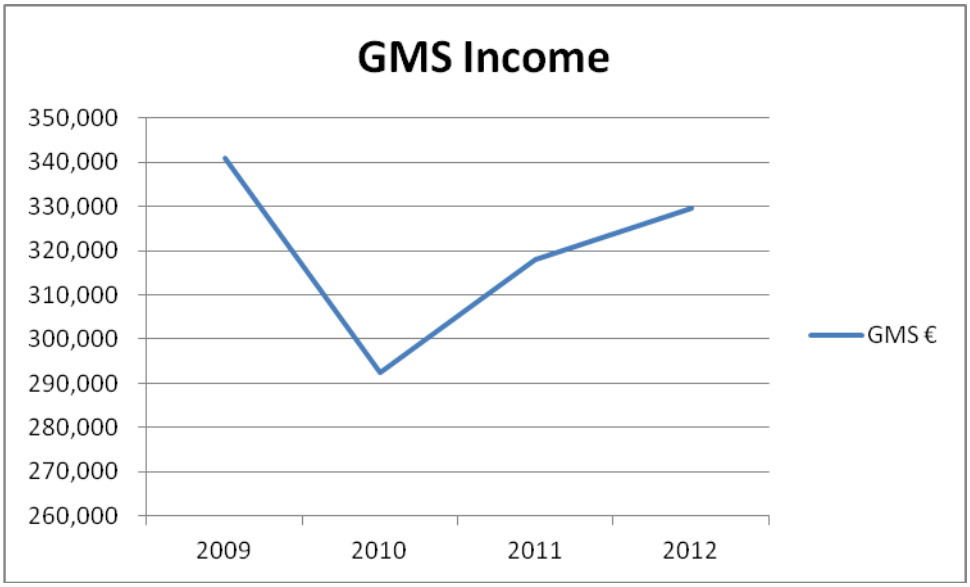


Figure 3: Total Income Paid on GP Fees & Allowances (GMS)

In common with all service providers GPs have to look to their cost base and have addressed any area to gain greater efficiency. Each area of cost has been carefully examined and where it was possible to make savings they have been already made. 92% of GPs have confirmed they do not have any further scope to reduce their fixed costs. The objective at all times has been to introduce greater efficiency without effecting front line services. Unfortunately GPs have increasingly reported they had to look at staff costs which are the major area of overhead and have made reductions. These changes cannot be implemented without a discernible effect on services. The challenge has been significant as the overall GMS income to general practice hovers around €300M it does not take account of the 426,674 increase in patient numbers who require additional consultations and consume significant resources in the course of their treatment. The more meaningful basis of comparison is the income per patient which is set out in the graph below

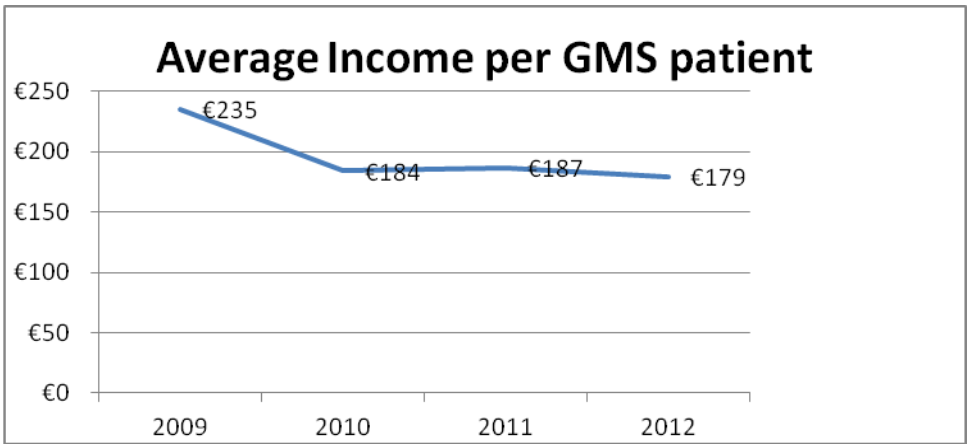


Figure 4: Average Income per GMS Patient

The on-going struggle to maintain existing service levels is exacerbated by the delays in access for patients to treatment in hospitals as well as additional HSE services. The prolonging of the treatment of patients impacts on the quality of their care and the opportunity for a successful outcome. The cost implications are clear as more delays are experienced the costs increase exponentially.

5. Increased Referrals

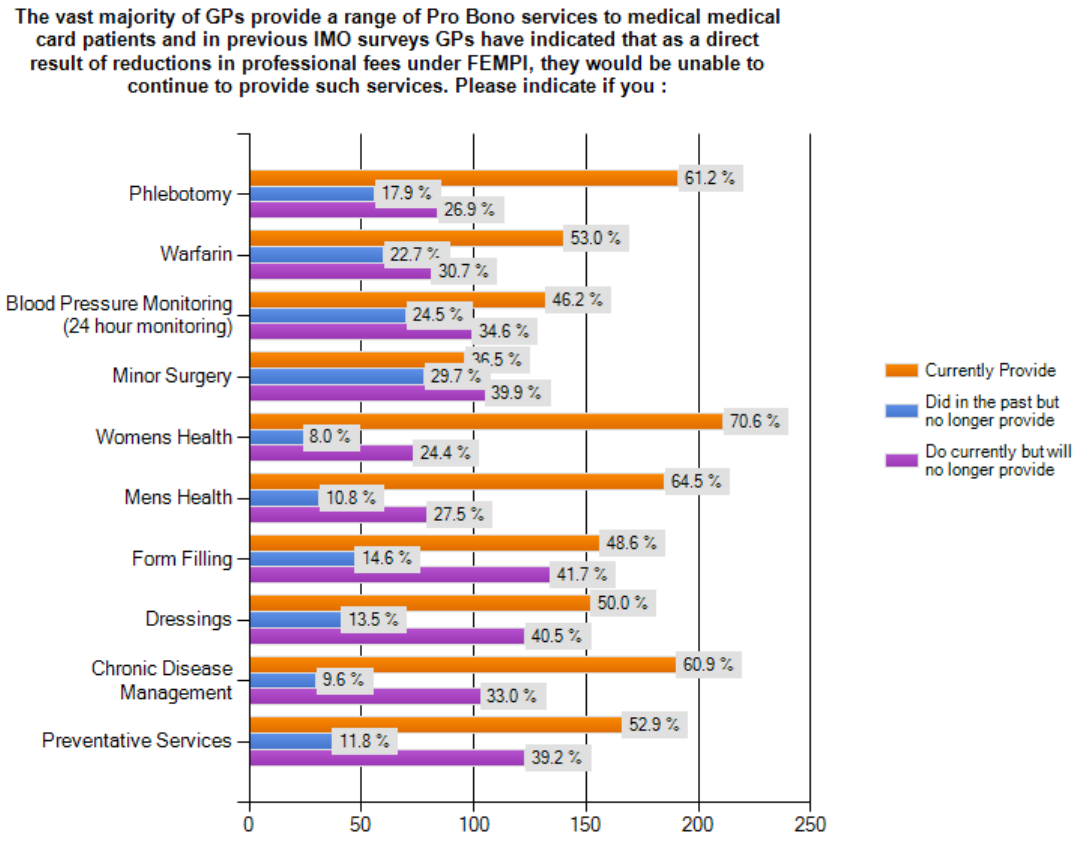
It is clear since the application of cuts that the out of hours activity has increased and the level of referral to emergency departments has increased. A review of an out of hours service figures by the IMO (Figure 5) covering a population sample of 600,000 people has shown an increase in out of hours referrals as well as an increase in the level of referrals to the emergency department

Figure 5: Out of Hours Referrals

6. Future prospects

The effect of an increase in the level of patient activity at the same time that income has fallen has generated significant pressure in general practice. While this has been common to all practices it is more acutely experienced in rural practices and those who deal with larger numbers of nursing home patients. The application of previous cuts has been disproportionate in its effect, crude in its application and has impacted those patients who are most vulnerable and very dependent on the services of their GP. These people who live in nursing homes and rural areas are the silent victims of these cuts who are those without a voice and forgotten.

Already GPs have been forced to reduce staff hours with the knock on effect on services to patients; the effect of any further reduction is self evident. 77% of GPs have informed the IMO they will have no option but to reduce staff hours of these 92% have confirmed this will involve cutting patient services. The expected action of GPs in response to the Budget 2013 announcement has been summarised by the inclusion of the table below.



While the level of 'pro bono' service is still significant since GPs recognise that these services are important for the welfare of patients it is reported that services are already curtailed in response to previous cuts. Having considered their options GPs now recognise that many of the additional services they have traditionally provided may not be sustainable as the level of resources are reduced and they make difficult choices about what will be available and what must be withdrawn. Form filling predominantly involving interaction state with state bodies has increased exponentially and such additional services involving a significant proportion of such activity are likely to be the first services to be withdrawn. The scope of other services alleviates significant pressure on the hospital system, at greatly reduced cost, and the withdrawal of other facilities such as preventative services, dressings, minor surgery and 24 hour blood monitoring can only result in even greater pressure on the hospital system.

It is incredible that a government which professes the creed of value for money by providing greater services at reduced cost should take this step which has the exactly opposite effect. Consistently it is the old the sick and the needy who most avail of these services and who will be most affected by these changes.

The further implications of any fee reduction are set out as;

i. IMO to fight any further fee reduction

Any further direct cuts to general practice are unwarranted and unacceptable to the IMO. The Medical Council highlights for doctors that *"Patient safety and quality of patient care should be at the core of the health service delivery that a doctor provides. A doctor needs to be accountable to their professional body, to the organisation in which they work, to the Medical Council and to their patients thereby ensuring the patients whom they serve receive the best possible care."* It is vital for

policy makers to understand that GPs must rise to the challenge to ensure that they fulfil their role as patient advocates. All GPs have confirmed their view that as a result of more referrals, waiting lists and the continuity of care for patients will be compromised It is a significant responsibility for GPs to oppose any further cuts to general practice and vital to the needs of their most vulnerable patients. As the representative body for doctors the IMO must take up the task to oppose any direct cuts to general practice front line services which are poised to disadvantage the old and the vulnerable. Cuts to these services would be inequitable and impact on those who can least afford to carry them. Any such approach would be contrary to the government stated aims of fairness and equity and would fly in the face of the slogans which suggest that cuts should be borne by those most able to afford them.

ii. Cuts will hit the most vulnerable

In seeking GP views for this document 98% of GPs were of the view that the greatest impact on care will be for the frail, the elderly, mentally impaired, children and those with literacy problems. They also believed that attracting GPs to rural and disadvantaged areas is now a critical issue.

iii. GP Waiting Lists Inevitable

This document highlights that the demand for GP consultations is increasing at a rapid rate which is putting the capacity of general practice under impossible pressure. The increase in demand is happening at a time when GPs cannot source locum cover when needed and are forced by reduced resources to reduce the number of GPs employed providing GMS services. The stress levels of GPs have reached a point where it is impacting on the health of doctors. It appears GPs who are mobile are looking at lucrative opportunities in other English speaking countries. Consequently the reduced capacity to deal with increased demand will inevitably result in unheard of rationing of GP care. This has been the experience in the UK where same day service from GPs is unheard of and many appointments are made weeks in advance. Subsequently patients who consider their condition urgent are increasingly likely to refer to the emergency services.

iv. Increased Referrals to other services

As the capacity of general practice falls and the demand increases GPs will experience even greater pressure than at present. This will reduce the time they have to delve deeper into issues raised by patients with the consequent increase in referrals to other services outside of general practice.

v. Ability to reduce drug costs curtailed

The inevitable shift from a more preventative model back to dealing with the immediate demands of patients will force GPs into reactive mode where they will deal with the immediate complaints presented by patients. This will be totally contrary to the aspiration to make savings to non front line services by using opportunities to reduce drug costs which while beneficial is both GP labour intensive and time consuming.

vi. Ability to modernise and enhance services to patients is curtailed

The track record of general practice in modernising services and responding to patient needs has been excellent. This has involved capital investment in premises, ICT and diagnostic equipment has enhanced treatment of patients in the locality and resulted in better outcomes for patients with the early prevention and detection of diseases. This has helped maintain the low referral rates to hospitals and provided a significant societal benefit. 100% of GPs have indicated they will not be in a position to develop premises or enhance diagnostic and/or technical equipment and practice

development will be stifled. They all believe that the lack of resources will result in an adverse impact on patients in the long term.

vii. Lost opportunity to providing Chronic Illness Management

The possibility of providing chronic care in the general practice setting has been raised in various reports and it is now clear that the future sustainability of the health system is dependent on a transformation to this approach. These diseases now account for the majority of health care expenditure and the incidence of many of them is set to rise. The solutions to the chronic care dilemma are to be found in General Practice. It can offer the state effective, deliverable whole population chronic disease management (CDM) that is cost effective, sustainable and real value for money. Such chronic disease management programmes, when resourced to provide the services to patients, are capable of delivering effective care for the current epidemic as well as being able to meet future demand in this country. This has been extensively researched, monitored and proven effective in the Irish pilot programmes and extensively described by the National Diabetes Programme. Any diminution of existing capacity in general practice will undermine the ability to provide these services and set this overdue initiative back by more years than the system can tolerate.

viii. Further erode the fabric of general practice

The IMO has previously reported on the impact of earlier cuts on GPs with increased stress level, higher level of work related ill health absence and difficulties in taking leave. These difficulties continue with over 50% of GPs increasing their **working day by 2 hours**. This situation is exacerbated by the fact that 66% of GPs have reported difficulty in obtaining a locum in the last 6 months. Anecdotal evidence suggests that locums are seeking more attractive posts outside of Ireland. It is further alarming that 57% of GMS GPs have reported to the IMO they have considered emigration to a GP post abroad with Australia (76%) Canada (59%) and the UK (39%) being their preferred option. As independent contractors 96% of GPs have confirmed the reduction in income has impacted on their ability to fund their pension. It is instructive that 82% of GPs have indicated they would not recommend working in general practice to relative/friend based on their current experience. The risks of a reduction in the number of GPs in Ireland cannot be overstated and combined with the looming demographic where 30% of existing GPs will retire within the next 15 years creates a bleak outlook for Irish healthcare. The costs and efforts involved in repairing this damage to general practice will be immense and should be avoided at all costs.

ix. Serious Setback for Universal GP Care

It must be clearly understood by policy makers that any further reduction to GP front line services will dismantle the capacity to meet the existing needs of patients. In addition to the effects that have already been outlined in this document it will almost guarantee that general practices capacity to introduce universal GP care will not be possible for at least 5 years and perhaps beyond depending on the nature of any cut to be applied.

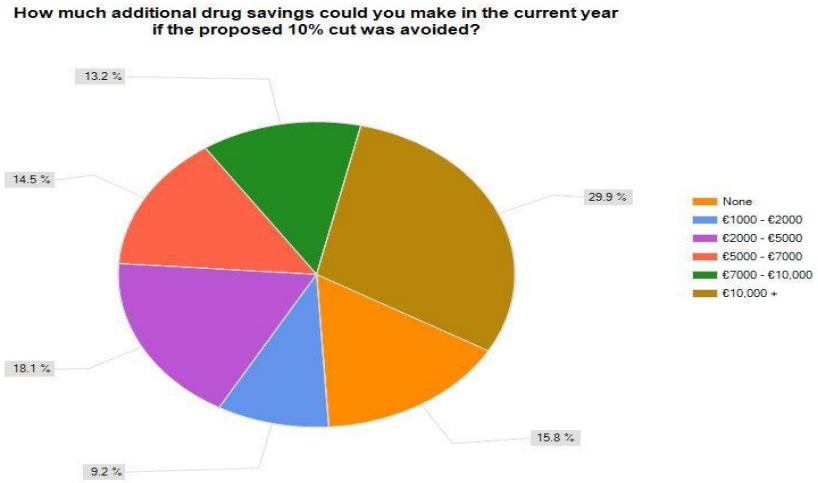
7. Immediate Action Needed

The cuts to date have had a serious and damaging effect on the provision of service in general practice. Any further cut will have a devastating effect on GP services and will unfairly impact on the old, the sick and the vulnerable. The argument set out earlier in this report shows that cuts have compounded the problems for rural practice and for those who deal with large numbers of nursing homes who have experienced more unfavourable treatment and have been put at an even greater

disadvantage. Of even greater concern is that the trend is getting worse and the disastrous impact will be considerable if action is not taken immediately.

The government may consider it unavoidable to reduce the spending in the primary care budget. However, it is essential that any reductions are applied with minimal impact on front line services. The challenge is to look at innovative ways of maximising our resources and using them in a way that meets patient needs and provides greater value for money. The IMO has considered these issues and has the means to achieve this aims. The IMO is ready to engage with stakeholders to turn this ambition into a reality.

An example of how savings could be made to meet the proposed reduction is illustrated by the following graph which illustrates that the full amount could be saved by additional drug savings based on what GPs estimate they could save.



The Minister and Department must ensure that Primary and Secondary legislation is proportionate and fair. It is clear that the further imposition of FEMPI cuts would be both disproportionate and unfair and will impact the most vulnerable in Society. This is notwithstanding that the IMO has clearly identified other areas in which savings could be achieved without such damaging effects to frontline services and it is encumbant on Government to give serious consideration to these potential savings as an alternative to such unfair and disproportionate cuts.

8. Conclusion

The challenge to balance the vital needs of patients, particularly the most vulnerable with the exchequer fiscal requirements is a difficult one. What is clear is that the costs of reducing care to those who need it most is measured in terms of health outcomes and the well being of the community as well as the financial cost. The savings made in avoiding prevention or in postponing treatment are illusory and only defer the cost incurred for a short time to be incurred again at a significantly greater rate. This does not take account of the quality of life of the patient and their loved ones. General practice provides good value for money and is prepared to engage on how this may be improved even further. The IMO would remind policy makers on the first principle of medicine *first to do no damage* and pleads the case to avoid reducing front line services and recognise there is another way.

In order to avert this disaster the minimal action required is;

- Commit to no further cuts to front line services provided in general practice.
- Engage with the IMO to agree an action plan to save the equivalent amount of money in ways that make savings but do not impact on patient services.
- Review of the impact of reductions in Out of Hours and Nursing Home payments on patients so these services become viable and facilitate a better service to patients with a great need.