

## **IMO Response to the Report of the Special Group on Public Service Numbers and Expenditure Programmes**

There is no denying the impact of the financial crisis on Ireland. Our economic landscape has been changed forever. This is a crucial time for change, and a crucial time to reconfigure the publicly administered elements that contribute to Irish society.

While the report of the Special Group on Public Service Numbers and Expenditure Programmes (McCarthy Report hereafter) was intended to make recommendations on value for money and potential public savings, some that have been offered are short-sighted in their approach. They propose hasty solutions that lack insight and show no scope to the social ramifications of such a tunneled approach to public finances. The fiscal targeting of the most vulnerable in our society will exclude whole populations from accessing the one source that promotes and often enables their involvement in the economic environment of Ireland: healthcare.

Through this submission, the Irish Medical Organisation hopes to draw attention to issues that clearly have not been acknowledged, investigated or understood, and implores the urgent reconsideration and revaluation of many of these recommendations. As the representative body of some of the front line staff, it is disappointing to think that these proposals are not being discussed more openly with the people delivering health care in Ireland. The IMO believes that focus should not just be on hastily proposed recommendations, but on sustainable, responsible and inclusive solutions. Before rash decisions are implemented, the IMO reminds the Government that we offer our hand in assistance, to provide understanding to the effects of these proposals and to assist them with their quest for quality and value for money in our health care service.

### **Detailed Paper 11 - Health and Children**

#### **Programme H – Primary Care**

##### **H1 - Medical Card Eligibility**

*Revise the income guidelines for the medical card to the basic rate of social welfare (Jobseekers Allowance) so that all existing non-medical allowances and HSE discretion are removed and replaced with a variable allowance based on medical need.*

*Annual savings €100m*

The IMO believe that the current income guidelines for receipt of the medical card are inadequate and any reduction in eligibility criteria will increase the level of hardship for those at the lower end of the income scale as illness goes under-diagnosed and undertreated.

Approximately 1.4 million people<sup>1</sup> are covered by a Medical Card for which eligibility is means tested. Current income guidelines are set below basic Social Welfare Payments with allowances made for reasonable expenses incurred in respect of rent/mortgage payments, childcare costs and travel to work. Around 981,500 qualify under the standard income means test, 343,500 people<sup>2</sup> hold an over 70s medical card and qualify

<sup>1</sup> HSE Performance Monitoring Report May 2009

<sup>2</sup> HSE Update on Over 70s Medical Cards March 2009

under a higher income threshold<sup>3</sup> (although the majority would qualify under the standard means test), and approximately 75,000 hold 'discretionary medical cards' where their income is above the guidelines but the financial burden of their medical or social circumstances causes them undue hardship.

The proposal outlined in the McCarthy Report would see the income guidelines for eligibility increase marginally but hides the loss of substantial income allowances for rent, mortgage payments, childcare fees and transport to work.

The current income threshold for a single person is €184 per week, while the current basic rate of social welfare is €204.30. If basic rates of social welfare are reduced by 5%, as also proposed, the income threshold for a single person will rise to just €194.10 per week. A married person with a dependant spouse and 2 dependent children will also see the income threshold rise from €342.50 per week to €372.40. It is unclear from the report how vulnerable groups such as single-parent families will be assessed. It is possible that the income threshold for a single parent with 2 children under 16 could fall from €342.50 per week to €243.50.

While the income threshold may increase marginally, the reduction in income allowances will be substantial. Exact allowances are unclear, but based on average costs (see below), for a person living in rented accommodation, travelling by bus to work with two children in community care - a weekly income allowance of €482.50 could potentially no longer exist.

Average rent <sup>4</sup>	€855 per month
Average mortgage repayments <sup>5</sup> for 1 <sup>st</sup> time buyers in Dublin	€1015 per month
Average mortgage repayments for 1 <sup>st</sup> time buyers outside Dublin	€749 per month
Average cost of subsidised community childcare <sup>6</sup> for toddlers	€117 per week
Average cost of subsidised community childcare for babies	€127 per week
Dublin short-hop bus ticket <sup>7</sup>	€34.50 per week

Replacing these allowances with allowances based on medical need would mean effectively the only people entitled to a medical card would be people whose sole income is derived from social welfare payments and the 75,000 people in receipt of a 'discretionary medical card'. The McCarthy Group have estimated annual savings of €100m, meaning over 60,600 people will lose their eligibility to a medical card. If the proposals are implemented, the IMO believe the number of people who will lose their medical card will be substantially higher.

As they stand, the current income guidelines are inadequate. Earlier this year, the Combat Poverty Agency<sup>8</sup> found that 22% of people (64,000 people, including 14,500 children) living in consistent poverty do not have a medical card and a further 30% of the population at risk of poverty (220,000 people, including 45,000 children) do not have a medical card.

<sup>3</sup> €700 per week for a single Person/ €1400 for a Married Couple

<sup>4</sup> daft.ie

<sup>5</sup> EBS and DKM Economic Consultants Affordability Index

<sup>6</sup> E.Kennedy, Childcare costs on the rise *Sunday Business Post*, 2 March 08

<sup>7</sup> dublinbus.ie

<sup>8</sup> Combat Poverty Agency 2009. Analysis of poverty impact of Budget 2009

The positive relationship between poverty and ill-health is well-documented. Available evidence shows that those on low incomes or in poverty have relatively high mortality rates, higher levels of ill-health and fewer resources to adopt healthier lifestyles. Research for Combat Poverty shows that people without a medical card are less likely to visit their doctor (with an average of 2.3 visits per annum) than medical card holders (6 visits per annum).<sup>9</sup> A recent study in the *Irish Medical Journal* has shown that the removal of entitlement to free health care under the GMS scheme has prevented patients from seeking medical attention and has caused them financial loss.<sup>10</sup> Early intervention is known to improve outcomes and reduce hospitalisation for major chronic diseases such as cancer, diabetes, cardio-vascular disease and COPD.

While the groups at high risk of poverty include the elderly, the unemployed, people with disabilities as well as single parent families - increasingly employed people on a low income or “the working poor” are living in poverty or are at risk. The 2007 Survey on Income and Living Conditions (SILC) in Ireland found that in 31% of households at risk of poverty and in 25% of households in consistent poverty the principal economic status of the head of the household was ‘at work’.<sup>11</sup>

The current means-tested medical card scheme offers the best way of targeting resources at the most disadvantaged and transparent standardised guidelines should be issued for the granting of medical cards. The IMO insist that under no circumstances should the income threshold for medical card eligibility be decreased.

The income guidelines should be set at the National Minimum Wage, so that everyone living in consistent poverty and at risk of poverty is covered and so that loss of medical card does not act as a deterrent to entering the workforce. Currently the minimum wage is set at €8.65 an hour. Based on a 39 hour week the income threshold for a single person would rise to €337.35 per week. Thresholds should be adequately adjusted for dependents and lone parent families.

## **H.2 – Drug Payments Scheme**

*Increase the threshold for the Drugs Payment Scheme from €100 to €125 per month  
Annual savings €37m*

## **H.3 Co-payments on Prescription Charges**

*Introduce a co-payment of €5 for each prescription under the GMS and Long Term Illness (LTI) Scheme  
Annual Savings €70m*

The IMO believes that increasing the threshold for the Drugs Payment Scheme will discourage the use of essential medication, ultimately leading to an increase in the use of health services. The IMO also believe that the introduction of co-payments for prescription drugs under the GMS and LTI schemes will adversely affect elderly and low income groups and those suffering from long-term disease.

<sup>9</sup> Layte R . Nolan A. Nolan B. Poor Prescriptions - Poverty and Access to Community Health Services *Combat Poverty Agency, Dublin 2007: xxiii*

<sup>10</sup> O’Carroll and O’Reilly There’s a Hole in the Bucket: An Analysis of the Impact of the Medical card Review Process on patient Entitlement to Free Health Care *IMJ 2008 101 (1)*

<sup>11</sup> CSO, Survey on Income and Living Conditions (SILC) in Ireland 2007 *Central Statistics Office, Dublin 2008: 36*

The US organisation RAND, in a review of 132 published studies, has shown that “increased cost sharing is associated with lower drug treatment, worse adherence among existing users and more frequent discontinuation of therapy”.<sup>12</sup> Evidence suggests that for each 10% increase in co-payments, prescription drug spending decreases by between 2% and 6%, depending on the class of drug and the condition of the patient. An increase of 25% of the threshold for the Drugs Payment Scheme could see a drop in the consumption of necessary medication by up to 15%.

Improvements in medical treatments have contributed to a steady decline in mortality rates from ischaemic heart disease and stroke in Ireland since 1997. The RAND review also found that “increased cost-sharing is associated with adverse medical events such as hospitalisations and worsening clinical outcomes over 1-2 years for patients with congestive heart failure, lipid disorders, diabetes and schizophrenia”.<sup>13</sup>

Further research has found that co-payments are associated with adverse outcomes particularly among vulnerable groups such as the elderly and the poor.<sup>14</sup> As mentioned above the GMS scheme serves the health needs of the elderly, people with low income and people with substantial medical need. The LTI Scheme entitles patients to full drug reimbursement irrespective of income if they suffer from one of sixteen chronic illnesses including cystic fibrosis, diabetes mellitus, multiple sclerosis and Parkinson’s disease.

The introduction of a €5 co-payment for each prescription under the GMS and LTI Scheme would see vulnerable patients pay an average of €5 per month towards their medication. The low uptake of the GP Visit Card shows that charging co-payments for medication does not serve the health needs of people on a low income. GP visit card holders find themselves in a difficult predicament - aware of their diagnosis but unable to afford their treatment.

Out-of-pocket payments for healthcare adversely affect people on low income who are not protected by a medical card nor private health insurance. Numerous policies have recognised this inequity but failed to address it adequately, including the introduction of the GP Visit Card and tax relief on health expenses.<sup>15</sup>

Co-payments have been introduced in countries such as the UK, the Netherlands and France to deter over consumption and curb healthcare expenditure, however, most countries that operate a system of co-payments for pharmaceuticals have universal coverage and provide a safety net that protects vulnerable groups such as children, people on low income or those with long term illness or disability. A recent review of Healthcare Payment Systems by PricewaterhouseCooper’s Health Research Institute<sup>16</sup> found that “Increasing out-of-pocket payments” ranked lowest in a survey of the best ways to manage demand.

---

<sup>12</sup> Goldman DP, Joyce GF, Zheng Y, Prescription Drug Cost Sharing – Associations with Medication and Medical Utilization and Spending and Health, *JAMA* 2007; 298 (1) 61:69

<sup>13</sup> Goldman et al 2007; 64

<sup>14</sup> Goldman et al 2007; 65

<sup>15</sup> Smith S. Equity in Health Care: A View from the Irish Health Care System. An Adelaide Health Policy Brief, *Adelaide Hospital Society, Dublin, 2009*

<sup>16</sup> PricewaterhouseCooper’s Health Research Institute, You Get What You Pay For – A Global Look at Balancing Demand, Quality, and Efficiency in Healthcare Payment Reform 2008

GPs are currently committed to achieving savings on drug expenditure in the region of €65 million per annum in line with the recommendations in Dr Michael Barry's report *Economies in Drug Usage in the Irish Healthcare Setting*. The IMO believe that the approach outlined in this report will yield more significant savings and recommend its full implementation.

#### **H.4 – GMS Contract**

*Invite tenders by open competition to provide services under the GMS*

*Annual savings €370m*

The IMO strongly believe that putting the GMS contract out to tender would lead to the corporatisation of primary care and the dismantling of community general practice. Inviting tenders will force small community practices into competition with large corporately owned health care centres or clinics for the provision of services under the GMS. Unable to compete community practice which has been built up over decades, will be forced to close down or will be absorbed by the larger corporations.

The independent contractor model of general practice, which provides quality of care and value for money, will be replaced by a corporate model of care with dire consequences on quality and accessibility to services - representing a poor return for the tax-payer's money.

#### **The Corporatisation of Primary Care and the Dismantling of Community Practice**

Introducing an open tender process to provide services under the GMS, welcomes large medical corporations into the delivery of primary care services in Ireland and will pit GPs against GPs and GPs against medical corporations in bidding wars for GMS contracts.

Under current arrangements, to be eligible for a GMS post or contract, doctors must have graduated from a recognised specialist GP training scheme. Suitable GP, hospital and research experience is also taken into consideration. Opening up the GMS contract up to tender will allow private companies with no experience in healthcare to operate services under the GMS and GPs will become mere employees.

As specialists in health care, GPs are ill-equipped for the tendering process compared to large private companies. The time required to compile the bid and the cost involved in preparations, puts GPs at a distinct disadvantage in the process<sup>17 18</sup>. Ultimately quality of care, which is difficult to quantify, is sacrificed for the bottom line. In a case study undertaken by Cole in the UK, bidding for an APMS (Alternative Provider of Medical Services) contract between two GP practices and a multi-national company who had no experience in delivering general practice came down to non-clinical issues such as managing a multiuse building, procurement, branding and price with the multi-national winning the bid at generally 6% lower costs than the general practice bids<sup>19</sup>.

The GMS Scheme is the most significant State contract held by General Practitioners. Over 2000 GPs hold GMS contracts with panels of on average of 650 GMS patients. The majority of practices provide some level of GMS service and possession of a GMS

<sup>17</sup> Cole, A. Primary Care Private Practice, *BMJ*, 2008;336:1406-1407

<sup>18</sup> Ellins, J. Ham, C and Parker H, Opening up the Primary Care Market, *BMJ*, 2009; 338

<sup>19</sup> Cole, A. 2008

list is regarded by GPs as important in the successful long-term development of a practice, particularly in rural areas.

Over the decades, GPs in Ireland have developed a comprehensive range of services including the development of maternity and infant care and the management, early detection and prevention of chronic disease, many of which are provided to GMS patients outside of contract arrangements. The provision of these services has only been possible through the development of core in-practice teams of GPs, nurses and administrative staff and substantial investment in infrastructure and technology.

Without the GMS contract, General Practitioners would see a dramatic drop in their practice income leading to cuts in services provided. Down-sizing of services would be in direct contradiction of government policy to develop Primary Care Teams in the community. Reduced resources will seriously inhibit the ability of general practitioners to engage meaningfully in the development of local Primary Care Teams. Practices may no longer be able to cater adequately for non-GMS patients and many will eventually be forced to close or be absorbed by large private medical corporations.

Under the Government Health Strategy, health care services have progressively transferred from secondary care to primary care without an associated transfer of resources. The IMO would have grave concerns about the channelling of already inadequate public funding for primary care to commercial companies and its effect on clinical autonomy. Obvious tensions exist between the physicians role to act in the best interest of the patient and that of a commercial body whose prime concern is to make profit for their shareholders.

### **Quality of Care and Value for money**

The GMS scheme has been in existence since 1972. Provision of services under an independent contractor model of general practice has served the needs of those entitled to a medical card well. Its key strengths include value for money ; continuity of care; gate-keeping; high patient satisfaction; equal access for public and private patients; same day service; flexibility in responding to health crises as they arise; 24 hour / 7 day service, 365 days a year; extensive network of GP centres of practice and easily accessible service.

By contrast, the corporate model of primary care offers poor value for money and poor quality of care. Particular issues include: failure to provide continual care; 'cream-skimming'; inability to deal with long-term complex illnesses; double doctoring; increased diagnostics; increased referrals and access issues. Particular lessons can be learnt from the experiences of Canada, the UK and Australia.

Over the past 30 years Canada has seen the development of large, free standing walk-in clinics that provide a gap between emergency departments and family physician offices and offer out of hours care for those who need it with no appointment necessary.

Many papers have identified the cost to the Canadian government of walk-in clinics in terms of the duplication of services and the lack of continuity of care<sup>20 21 22</sup>. The

---

<sup>20</sup> Weinkauf, D, Kralj, B. Medical Service Provision and Costs: Do Walk-In Clinics Differ from Other Primary Care Delivery Settings, Canadian Public Policy – Analyse de Politiques, 1998 Vol. XXIV, No 4

<sup>21</sup> Miller GB, Nantes S. Walk in clinics and primary care. *Can Fam Physician* 1989;35:2019-22.

establishment of such clinics has led to growing criticism of the primary health care in Canada, particularly in regards to value for money. Such issues include:

- the failure to provide continual care: where in order to achieve greater profit and increased efficiency, patients see whatever GP is available, not necessarily the same one.
- double doctoring: patients tend to follow-up with their family doctor where services are repeated, with the provincial governments being double billed for what should have been a single trip.
- the nature of walk-in clinics are for patients with 'relatively minor episodic illnesses' resulting in 'cream-skimming.' These people are less likely to attend a walk-in clinic as a result of a long-term complex illnesses, and are comparatively healthy. These cases are less complex to treat and can often be dealt with quickly.
- the cost of billing for comprehensive assessments, as a high proportion are presenting for the first time, with no previous understanding of case history<sup>23</sup>.

In the UK, due the structure of the NHS system, corporatisation of Primary Health has only recently started to infiltrate the NHS system with the introduction of privately owned out-of-hours services in 2004 and followed by polyclinics into primary care delivery in 2007. Polyclinics are large health centres that offer a wide range of primary care services that will shift from a hospital to a community setting, such as antenatal and postnatal care, community care, social care and specialist advice and provide a 'one-stop-shop' for the patients. It has been recommended that there be 152 GP-led health centres (one for each Primary Care Trust (PCT) in England) providing seven day a week primary care services.

Concerns have been raised that:

- With the transferring of public resources from GP practices to commercial companies, does the loyalty lie with the patient or the shareholder?
- APMS contracts to run polyclinics are by nature short-term, potentially resulting in short-term approach to care by providers, contrasting greatly with the personalised care of GPs.
- Due to the arrangement of polyclinics, the engagement of multiple doctors may result in a lack of continual care for patients particularly those with long term conditions.
- Polyclinics may be further away from their local GP office, which may create accessibility issues<sup>24</sup>.

The corporatisation of primary care in Australia has been continually evolving for almost 30 years, with an increasing level of medical centre ownership by corporations, individuals and doctors with and without a clinical practice<sup>25</sup>. While various models have

---

<sup>22</sup> Also see references made in Brown JB, Bouck LM, Ostbye T, et al. Walk-in clinics in Ontario. An atmosphere of tension. *Can Fam Physician* 2002; 48: 531-536.

<sup>23</sup> Weinkauf, D, Kralj, B. Medical Service Provision and Costs: Do Walk-In Clinics Differ from Other Primary Care Delivery Settings, *Canadian Public Policy – Analyse de Politiques*, 1998 Vol. XXIV, No 4

<sup>24</sup> The impact of polyclinics on family doctor services, British Medical Association, April 2008, [http://www.bma.org.uk/healthcare\\_policy/nhs\\_system\\_reform/Polyclinics.jsp](http://www.bma.org.uk/healthcare_policy/nhs_system_reform/Polyclinics.jsp)

<sup>25</sup> AMA General Practice Corporatisation – AMA Scoping Paper, Australian Medical Association, November 2000.

been established a particular model of 'vertically integrated' practices has evolved where there are a

*...concentration of general medical practices under a corporate umbrella, in association with other services such as pathology, diagnostic imaging, and specialist services, to generate profits for third parties who are currently often not directly involved in the provision of medical care services. The profit generated from these co-locations and the resulting inter-referrals are directed to outside shareholders or other third parties<sup>26</sup>.*

These types of clinics are likely to expand across Australia with the proposed establishment of Comprehensive Primary Health Care Centres, commonly known as GP Super Clinics. A major issue with this model is the potential of corporate priorities, to influence ethical standards of doctors, as well as the volume and direction of referrals<sup>27</sup>. This is because profits are made either because activities are cross-subsidised within clinics or because of "cherry picking" - referring more difficult less remunerative work to specialists.<sup>28</sup>

In all three countries, Medical Organisations felt that public funds would have been better invested in current infrastructure rather than creating competing structures alongside.

The IMO is concerned that a corporate model of primary care will not only represent poor value for money but will have severe implications on the quality of care received by both GMS patients and patients who suffer from long-term or chronic illness.

### **Continuity of Care**

Continuity of care is one of the best ways of keeping costs down and is a key element of Ireland's Primary Care Strategy.

*Continuity of care allows health professionals to get to know patients. This has been found to be associated with time saving, reduced referrals, reduced prescriptions and improved compliance. The literature also shows that continuity of care is associated with improved recognition and management of patients' psycho-social problems.*

*Most research suggests that a patient's satisfaction with a consultation is strongly associated with visiting the same doctor. Studies which have looked at out-of-hours care provided by GPs from the patient's own practice versus those from deputising services have found that deputising doctors were less likely to give telephone advice, took longer to visit at home and were more likely to prescribe medication. Patients were more satisfied with services provided by their own doctors.<sup>29</sup>*

---

<sup>26</sup> AMA 2000.

<sup>27</sup> AMA 2000.

<sup>28</sup> AMA GP Super Clinics Initiative – Comments on the draft Program Overview, Australian Medical Association, 15 April 2008, pg 5.

<sup>29</sup> Primary care – A New Direction

If the GMS contract was opened up to tender a large proportion of both GMS patients and non-GMS patients would be forced to change GP. If the corporate model of health care is adopted all continuity of care for these patients is likely to be lost.

Disruption in the continuity of care is likely to result in constant recounting of complex symptoms, an increase in referrals for diagnostics and for admission into hospital, dramatically increasing patient cost and placing pressure on an already overstretched healthcare system.

### **Chronic Disease Management**

Continuity of care is also an essential part of chronic disease management (CDM). Patients with chronic disease require services from a wide variety of healthcare professionals, along with self-management and the participation of family or carers. Often the majority of care is provided at home with transfer to acute or long-stay facilities at intermittent intervals. CDM is therefore best suited to the General Practitioner who can guide patients to appropriate specialist or long-term care as well as provide advice on self-management and home-caring.

Also the close relationship between GP and patient that develops over time allows GPs to better detect changes in health status, the provision of preventative care and patient conformity to therapy suggestions from the GP<sup>30</sup>. Research also suggests that good patient-physician continuity is 'associated with a decreased likelihood of future hospitalization, as well as decreased emergency department use'<sup>31</sup>.

GPs also currently provide a range of services focused on the management of chronic disease to their GMS patients which are over and above their contractual obligations. These include:

- Warfarin monitoring;
- 24 hour ambulatory blood pressure monitoring;
- Chronic disease management including diabetes management, asthma management COPD management, joint injections for arthritic conditions;
- Preventative services such as health checks, haemochromotitis screening, cholesterol testing etc.

As mentioned above, large clinics are ill suited to the needs of patients with chronic disease as they disrupt continuity of care and have a tendency to "cherry pick" low-cost lucrative treatments rather than providing a full range of cost intensive emergency, complex or chronic care.

Under a corporate model of care services currently provided on a *bona fide* basis are likely to be lost. The GP gatekeeper role as a guide to the health system will also disappear as people with long-term and chronic illness are referred needlessly to specialists or present at A&E.

---

<sup>30</sup> Bolton, P. Sustaining Quality General Practice in a Flawed Market. Australian Family Physician, Vol 32. No 4, April 2003.

<sup>31</sup> Mainous III AG. *Continuity of care and trust in one's physician: evidence from primary care in the United States and the United Kingdom*. In: Baker R, editor. 2000 North American Primary Care Research Group Meeting; 2001 January 2001: Fam Med 2001; 2001. p. 22-7.

### **Choice of GP and Accessibility**

When filling new GMS posts, the HSE currently give due consideration to the provision of proper level of services, choice of GP and the viability of practices in an area.

Due to poor consistency and quality of care under a corporate model, Medical card holders and sufferers of chronic disease will be left feeling disillusioned with the primary health care system and frustrated through lack of alternative care.

Large clinics also require substantial catchment areas and are unlikely to locate outside of the larger cities and towns in Ireland. Medical Card holders are either people on low income, the elderly or people with substantial medical need. Travelling to a centre to avail of GP services previously provided locally will pose a substantial financial and physical burden to the patient, particularly in rural areas, discouraging visits to the GP and eventually placing pressure on hospital services as undiagnosed and untreated patients end up in A&E.

At just 58 GPs per 100,000 population<sup>32</sup>, there is currently a shortage of GPs in Ireland which particularly affects rural areas. The manpower shortage is likely to continue due to current GPs reaching retirement, the feminisation of General Practice and the increasing transfer of services from secondary to primary care.

Any tendering process which will unquestionably serve to undermine the career prospects, security of tenure and personal income of entrants to General Practice will undoubtedly make General Practice a less attractive career to work in or stay employed in. It is likely that any immediate financial gain would be eroded in the short-to-medium term by the need to improve funding of General Practice sufficiently to attract and retain an adequate supply of fully trained General Practitioners going forwards.

Doctors would also feel disillusioned and angry with this measure and any attempt to tender out the provision of GP services under the GMS would pose significant contractual, legal and industrial relations difficulties for the State.

### **Programme I – Acute Hospitals**

#### **I.1 – Increase Hospital Charges**

*Increase the standard charge for those presenting at A&E Departments without a letter from their GP to €125 and increase public hospital inpatient charges by 20%.*

*Annual increase in revenue €6m*

The proposal to increase the government levy for those attending emergency departments (ED) is short-sighted and misunderstands the function of both the levy and EDs. While the levy encourages patients to visit their GP prior to attending the hospital, the downside to this is that the delay in certain patients reaching the ED is likely to cause an increase in morbidity and mortality. As with recommendation H.2 above, an increase in hospital charges (both ED and inpatient) will largely affect people on low income who have neither a medical card nor health insurance to cover health expenses.

---

<sup>32</sup> Expert Group on Future Skills Needs, A Quantitative Tool for Workforce Planning in Healthcare: Example Simulations, FAS 2009

The McCarthy report identifies increasing ED charges as a measure aimed at “reducing inappropriate demand”. Research at home and abroad,<sup>33</sup> shows that increasing the levy deflects a proportion of patients, away from the emergency department, however, there is no reduction in the numbers presenting with problems that require admission to hospital – merely a delay in their presentation.

Current guidelines in Emergency Medicine relating especially to four large groups of patients emphasise the urgency of attendance at emergency departments. These groups are head injury, chest pain, sepsis and stroke. All medical professionals, including GPs, support these guidelines.

Modern management of these presentations is very time-critical and even a one-hour delay in reaching definitive treatment is likely to lead to an increase in mortality. Of greater economic concern is that such delays in presentation are highly likely to lead to increased morbidity, with delayed discharges and with greater dependence on the state health system thereafter. This is most especially so for stroke and heart attack, where thrombolysis is now a reality in Emergency Medicine.

Professional advice is that any patient who has even a suggestion of a stroke should immediately attend the emergency department, and not attend their GP. This is because the time within which to assess them, arrange to perform and read a CT scan and explain to them the risks and benefits of modern therapy is limited to a very tight time window of only three hours from the first symptom. The difference between having a person unable to walk, talk or look after their own daily needs, versus a complete or near complete recovery, with independent living is incredibly stark.

Patients with symptoms of stroke or chest pain who delay to see a GP may miss the window of opportunity for interventional cardiology or thrombolysis. Indeed it is now international guidance to go directly to the ED if you have symptoms of stroke. Every minute of delay results in loss of brain tissue and a less favourable response to thrombolysis and chance of maintaining independence. In suspected heart attack each hour delay increases the probability of heart muscle damage, leading to chronic cardiac failure, frequent use of the health care system and inability to work profitably in the future.

Recent research proves that patients with sepsis, who may merely feel very unwell, with ill defined symptoms and collapse, will survive better and recover faster if treated within 1 hour. To delay treatment beyond this invites long periods in the intensive care unit, which is an extremely expensive form of medical care. Early treatment reduces the length of stay markedly and may even obviate the need for admission to the intensive care unit.

---

<sup>33</sup> Reed M, Fung V, Brand R, et al. Care-Seeking Behavior in Response to Emergency Department Copayments. *MedicalCare* 2005 43(8): 810:816

Selby J.V. Fireman B.H. Swain B.E. Effect of a Copayment on Use of The Emergency Department in an HMO *N Engl J Med* 1996;334:635:641.

Smith S. Patterns of Emergency Department Utilisation in Ireland: Findings from Four Large teaching Hospitals in Dublin in Ed Nolan B. *The Provision and Use of Health Services, Health Inequalities and Health and Social Gain Dublin ESRI* 2007: 129:176

The current €100 charge for attending A&E, in place since January 2009, is already significantly higher than GP charges €45-70 and deters patients from using the Emergency Department. An increase of 25% in ED charges will deter others, principally those who are not covered by a medical card or private health insurance. Currently this group represents around 24% of the population<sup>34</sup> and is likely to increase if medical card eligibility drops and unemployment and health insurance costs increase.

Other avenues should be explored to prevent the inappropriate use of EDs, for example, enhanced direct access for GPs to diagnostic services and an alcohol policy to prevent accidents and injuries caused by alcohol abuse and drink-driving. The out-of-hours GP service is an important service which encourages people to attend the GP for minor injuries and ailments outside of normal practice hours. This should be expanded.

### **I.2 Charges for private patients in public hospitals**

*Increase charges for private facilities in public hospitals by 20%.*

*Annual increase in revenue €50m*

The IMO agrees that charges for private facilities in public hospitals should reflect actual costs including economic costs and has prepared a detailed submission to the DOHC for the *Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals*.

The IMO are also adamant that the current co-location project – to locate private hospitals on public hospital grounds – will negate any increase in revenue raised by this recommendation and will ultimately result in a substantial loss of revenue to the public system. The exact amount of revenue that will be lost due to the co-location project is difficult to estimate, although there have been reports in the media of a €100m annual loss.

The IMO also believe that because private hospitals ‘cherry pick’ low-cost elective care, rather than providing a full range of cost intensive emergency, complex or chronic care. The co-location project will not only lead to a loss of revenue but will neither address the issues of acute bed capacity nor equity of access to health services. The IMO calls for the co-location project to be reversed immediately.

### **I.3 Generic Prescribing**

*Introduce mandatory protocols requiring hospitals and clinicians to prescribe generic medicines, off-patent drugs and value for money high-technological treatments.*

*Annual savings €30m*

The IMO supports measures to encourage the use of generic and off-patent drugs as well as value for money high-technological treatments throughout the health service, however, the IMO believes that unless the price of generic drugs in Ireland is reduced substantially, predicted savings are unlikely.

Ireland has a very poor record in terms of generic prescribing. In 2007 just over 19% of prescription items were dispensed generically, while in the UK it is estimated that 83% of

---

<sup>34</sup> Health Insurance Authority and Central Statistics Office

prescriptions were issued generically with 64% dispensed generically.<sup>35</sup> In the USA, generic drugs are on average 30-80% less expensive than the branded version.<sup>36</sup>

Generic prescribing across the health system should be encouraged. Hospital doctors have a particular role to play. Many prescriptions particularly those written under the High Tech Drugs Scheme are written by hospital doctors, which GPs are later reluctant to change.

Generic prescribing can be encouraged by the provision of prescription software systems, prescription data analysis and professional prescribing advice and support,<sup>37</sup> however, certain drugs do not have generic alternatives and strict guidelines should be introduced for patient safety.

The IMO is concerned that unless the cost of generic drugs are reduced substantially, generic prescribing is unlikely to achieve the predicted savings.

Prices of pharmaceuticals ex-manufacturer are fixed by agreement between the IPHA and the HSE. Under the 2006 revised agreement the price of medicines in Ireland are linked to prices in nine EU states including Austria, Belgium, Finland, Denmark, France, Germany, the Netherlands, Spain and the UK. The pharmaceuticals sector also agreed to a 35% reduction in patent expired medicines.

Despite this, generic prices remain substantially higher in Ireland than in the UK. *The Irish Independent* reported that manufacturers in the UK charge €1.11 for the generic ulcer drug Omeprazole while the cost charged in Ireland is €20, Lansoprazole, is sold by manufacturers in the UK for €2.44, but costs €21 for the same quantity here and the Generic angina drug Amlodipine costs 49 cents, but is €8 here.<sup>38</sup>

The EU's *Pharmaceutical Sector Inquiry – Preliminary Report* also found that in Ireland, one year after patent expiry, generic prices remain on average at 80% of the originator price.<sup>39</sup>

The IMO is committed to achieving savings on drug expenditure and in this regard has already participated in Dr Michael Barry's Report *Economies in Drug Usage in the Irish Healthcare Setting*. The Report identifies savings in the region of €65 million. However, the IMO believes that, with radical measures, there is potential to achieve savings in the region of €300 to €400 million a year across the health system.

Savings can be achieved on two fronts:

- a) By reducing the level of expenditure and
- b) By reducing the rate of growth in prescriptions

---

<sup>35</sup> Barry J. Economies in Drug Usage in the Irish Healthcare Setting, *National Centre for Pharmacoeconomics 2009*

<sup>36</sup> Woolston C, Levine S Generic Drugs *Consumer Health Interactive* downloaded from [www2.vhi.ie/topic/genericdrugs](http://www2.vhi.ie/topic/genericdrugs) on 12 Aug 09

<sup>37</sup> Barry J, 2009

<sup>38</sup> Phelan S, HSE Blows Millions On Overpriced Medicines, *The Irish Independent* 13 July 2009

<sup>39</sup> EU Competition DG, *Pharmaceutical Sector Inquiry – Preliminary Report November 2008*

The IMO recommends the establishment of a high level expert group to review all aspects of drug prescribing and supply, and in particular that the state:

- Examine the introduction of mandatory generic prescribing across the whole of the health system;
- Examine initiatives at the prescriber level to promote rational cost-effective prescribing;
- Introduce reference pricing without delay;
- Develop prescribing protocols, criteria and defined prescribing periods in respect of high cost drugs;
- Develop prescribing formularies at the level of the individual hospital and GP's practice;
- Develop protocols for patients being discharged from the hospital setting into the community;
- Carry out a comprehensive review of all reimbursable medicines to ensure that wasteful or inefficient medicines with little proven clinical benefit are excluded from reimbursement;
- Carry out cost-benefit analysis comparing newer (and frequently more costly) medicines with existing less costly alternatives;
- Establish an implementation group to drive the implementation of these measures.

## Programme K – Care of the Elderly

### **Fair Deal**

*K.1 Increase the percentage of care costs under the 'Fair Deal' contributed by an individual from their residence. Increase in Annual revenue €50m*

Under the current terms of the 'Fair Deal' programme, senior citizens who own their own property and have a weekly income (i.e. pension) will be subject to a financial assessment and expected to contribute towards their care in residential homes. This assessment will identify to what capacity a person can contribute 80% of their assessable income and 5% per annum of the value of any assets (including principle residence) capped at 15% or the first 3 years of care.

### Examples of impact

	Example A		Example B		Example C		Example D	
Value	€250,000		€300,000		€400,000		€600,000	
	Single	Couple	Single	Couple	Single	Couple	Single	Couple
Asset disregard*	€36,000	€72,000	€36,000	€72,000	€36,000	€72,000	€36,000	€72,000
Remaining Value	€214,000	€89,000	€264,000	€114,000	€364,000	€164,000	€564,000	€264,000
Proposed 22.5% Contribution	€48,150	€20,025	€59,400	€25,650	€81,900	€36,900	€126,900	€59,400
Current 15% Contribution	€32,100	€13,350	€39,600	€17,100	€54,600	€24,600	€84,600	€39,600
<b>DIFFERENCE</b>	<b>€16,050</b>	<b>€6,675</b>	<b>€19,800</b>	<b>€8,550</b>	<b>€27,300</b>	<b>€12,300</b>	<b>€42,300</b>	<b>€19,800</b>

\*N.B. If the residence belongs to a couple, value is divided in half after the couple rate of asset disregard is deducted.

\*These costs do not take into account the other mandatory contributions that patients will have to make, including 80% of weekly income along with any other cash contributions determined during the financial assessment.

The McCarthy report recommends that the percentage of care costs contributed by an individual from their residence be increased to a maximum of 22.5% over three years. Therefore, people under the Fair Deal scheme will now be paying 7.5% per year instead of 5% per year. While the process and mechanism of valuation needs clarification the potential impact these changes could have on an individual's or a couple's contribution is illustrated above.

The IMO is concerned that the increased asset contribution, in addition to 80% of weekly income is unfair on those who have worked hard to provide for families throughout their lives. Patients enter long-term care only when all other avenues have been explored. Older people and their families have often made Herculean efforts to stay at home for many years and often a family member has taken substantial time out of their working life to care for a relative at home.

When the Fair Deal programme is implemented the National Treatment Purchase Fund has a special remit from the state to negotiate fees for private and voluntary nursing homes. Given the NTPF's track record negotiating rates and procuring services from the private sector, the IMO fears that unless the NTPF's purchasing policies are reexamined the fair deal programme will also fail to provide value for money to those who have relinquished a substantial share of their assets to avail of the scheme.

Furthermore the IMO also believe that the Fair Deal programme is unlikely to succeed as a mechanism for funding long-term care unless the shortage of public long-term nursing-home beds is addressed.

Patients may require access to public long term care rather than private care due to financial reasons, or due to the ability of such services to care for higher medical need and/or higher dependency level patients. The majority of long-term beds are provided by private nursing homes that are unable to care for all patients who present to them. Over the past two years, the HSE has reported a significant growth - from 70 per week to 260 per week - in patients either requiring or requesting access to a public long term care bed.<sup>40</sup> Although private nursing homes can manage care for some older people, there is a clear need to provide a significant increase in the proportion of care in public nursing homes.

### **Homecare Packages**

*K.2 Introduce a means test for Homecare packages*

*Annual Savings €24m*

While the IMO supports the immediate clarification of eligibility criteria for receipt of Home Care Packages, the IMO believes the introduction of means testing based on the eligibility criteria for home-help hours is misguided and contradicts the central objective of the Scheme - to allow elderly people live independently for as long as possible in their own homes.

Even though home-help hours may be part of a Home Care Package, to treat them with similar financial criteria would be unfair to the recipient. Home help hours 'usually assist

---

<sup>40</sup> HSE 2009 *HSE Performance Report March 2009* p28

people with normal household tasks although they may also help with personal care<sup>41</sup> whereas Home Care Packages 'may include the services of nurses, home care attendants, home helps and the various therapies including physiotherapy services and occupational therapy services<sup>42</sup>.' Although the mix of services is dependent and tailored to patient needs, the expense involved can be quite considerable if heavily dependent on therapeutic or nursing care, as opposed to having sole home help to assist with household tasks. Such comparison between home help hours and Home Care Packages are totally misguided as their fundamental nature is very different along with the rates at which they are charged. Additionally, the flexibility of the packages need to be considered, some people may need a more complex mix of services for a period of time, only to be downgraded once better health is achieved, or vice versa.

As the main recipients of the Home Care Support Scheme are older people, it is important to look at their financial capability in affording prescribed services. According to the HSE the rates of support packages may be worth between €350 and €500 euro per week<sup>43</sup> while the average income of people over 65 is estimated at about €260 per week and about 60% of people over 65 have a weekly income of less than €300<sup>44</sup>. Clearly such a discrepancy between income and the cost of the package necessitate financial support from the HSE in order to remain independent in the community.

Faced with increased costs towards services to remain independent, some may choose to enter a nursing home facility or acute health care setting for this period of time to avail of the Fair Deal Scheme or subsidised hospital costs. This contradicts the objectives of the Home Care Packages, and although the individual would generally favour the choice of assistance to live independently, such means assessment and weekly financial burden may force them into residential care, placing unnecessary pressure and on already overstretched public nursing home and hospital beds.

## **Detailed Paper 15 – Social and Family Affairs**

### **Programme C – People of Working Age**

#### **Treatment Benefit**

*C.2 Discontinuation of treatment benefit that contributes to the costs of dental, optical treatment and hearing aids. Annual savings €92m*

The IMO believe that the Treatment benefit Scheme contributes significantly to the health of Irish citizens and the cost to the State in abolishing this scheme far outweighs the savings.

As dental, ophthalmological and audiologist services are generally independent of GP services, some patients, again those on low incomes without healthcare coverage, will now have to prioritise their healthcare financially if these recommendations are adopted.

---

<sup>41</sup> Home Help Service, HSE, [http://www.hse.ie/eng/HSE\\_FactFile/FactFile\\_PDFs/Other\\_FactFile\\_PDFs/Home\\_help.pdf](http://www.hse.ie/eng/HSE_FactFile/FactFile_PDFs/Other_FactFile_PDFs/Home_help.pdf) Accessed 04/08/2009

<sup>42</sup> Home Care Support Scheme for Carers, HSE,

<sup>43</sup> Home Care Support Scheme for Carers, HSE,

<sup>44</sup> The nursing Homes Support Scheme 'A Fair Deal' – Frequently Asked Questions, Department of Health and Children, July 2009.

While discontinuing this service proclaims to save €92 million euro, there is no talk of what the implications of doing so will cost down the line. The economic implications of unmanaged eye diseases and dental problems, things such as accidents from deteriorating sight, disability payments for conditions that could have been prevented, inability to contribute to the workforce due to loss of sight or hearing – all of these are real outcomes if the discontinuation of the treatment benefit goes ahead.

### **Carer's Allowance**

#### *C.3 Phase out half rate carer's allowance*

*€7m savings year 1 rising to €70m over time*

The IMO believe the contribution made by carers of incapacitated people of all ages must be recognised and supported. The half-rate carer's allowance is paid weekly to carer's already in receipt of a social welfare payment and amounts to €110.25 for care for a person under 66 years and €119.50 for a person over 66 years. This increases to €165.37 for care for 2 people under 66 years and 179.25 for care for 2 people over 66. The weekly salary for a full-time home help worker ranges from €528.06 to €586.95<sup>45</sup> while long-term nursing home care ranges from €800-1000 per week. It is estimated that the country's 161,000 carers save the exchequer approximately €2.5 billion a year.<sup>46</sup>

Carers need financial support to enable them to care for someone as long as they wish and are able to do so, without jeopardising their own health and wellbeing, financial security, educational opportunities or reducing their expectations of a reasonable quality of life. The IMO believe the full and half-rate carer's allowances should be increased not reduced.

### **Conclusion**

The IMO is in firm belief that the recommendations and targeted savings of the McCarthy Report are not realistic, achievable or sustainable. While on the surface the savings may appear significant, many do not account for other costs that will spring up as a result of the withdrawal of programs or schemes, or for changing criteria and capacity that will alter an individual's status in and access to the Irish health care system, and the ensuing problems this creates. Some of these recommendations are even harmful to Irish society, and will eventually result in the breakdown of public healthcare leading to a system based on financial ability rather than need.

The IMO implores the government to take on board the recommendations made and to readdress the issues that are raised within this response. Doctors in Ireland are voicing their opposition to such radical changes in the delivery of health care, their ability to operate in an underfunded, ill planned and resourced system, and have grave concerns for the well being of patients in Ireland.

---

<sup>45</sup> HSE, based on 39 hour week

<sup>46</sup> Care Alliance Ireland 2009 [www.carealliance](http://www.carealliance)

## Summary of Recommendations

### Detailed Paper 11 – Health and Children

#### **Programme H - Primary Care**

- The income guidelines and allowances for eligibility for a medical card should under no circumstances be lowered.
- Thresholds should be increased to minimum wage in order to encompass all those living in or at risk of poverty.
- Increasing co-payments under the Drugs Payment Scheme and introducing cost-sharing for prescriptions under the GMS and LTI Schemes will discourage the use of essential medicines particularly for people on low incomes, the elderly and those suffering from long-term disease. These recommendations, therefore, should not be implemented.
- The IMO believe savings can be made through the implementation of recommendations outlined in Dr Michael Barry's report *Economies in Drug Usage in the Irish Healthcare System*.
- The IMO believes that inviting tenders by open competition to provide services under the GMS will lead to the corporatisation of primary healthcare and the dismantling of community general practice. Experience from abroad shows that the corporate model of care represents poor value for money. Patients and doctors will be left feeling disillusioned with the Primary Care system. Any attempt to tender out the provision of GP services under the GMS would pose significant contractual, legal and industrial relations difficulties for the State.

#### **Programme I – Acute Hospitals**

- Hospital charges, both for inpatients and those attending emergency departments (EDs) should not be increased as this will adversely affect people on low income whose healthcare is neither covered by a medical card nor by private health insurance.
- Increasing the government levy for those attending emergency departments will merely delay certain patients from presenting at A&E causing an increase in morbidity and mortality. The current €100 charge already encourages patients to attend their GP before attending A&E. Other avenues should be explored to prevent the inappropriate use of EDs, including expansion of the GP out-of-hours service, access to diagnostics, alcohol policy to prevent accidents and injuries caused by alcohol abuse and drink driving.
- Generic prescribing should be encouraged throughout the health service, however, the IMO believes that unless the cost of generic drugs are reduced substantially, generic prescribing is unlikely to achieve the predicted savings the IMO believes that, with radical measures, there is potential to achieve savings in the region of €300 to €400 million a year across the health system.
- The IMO recommends the establishment of a high level expert group to review all aspects of drug prescribing and supply, and in particular that the state:
  - Examine the introduction of mandatory generic prescribing across the whole of the health system;
  - Examine initiatives at the prescriber level to promote rational cost-effective prescribing;
  - Introduce reference pricing without delay;
  - Develop prescribing protocols, criteria and defined prescribing periods in respect of high cost drugs;

- Develop prescribing formularies at the level of the individual hospital and GP's practice;
- Develop protocols for patients being discharged from the hospital setting into the community;
- Carry out a comprehensive review of all reimbursable medicines to ensure that wasteful or inefficient medicines with little proven clinical benefit are excluded from reimbursement;
- Carry out cost-benefit analysis comparing newer (and frequently more costly) medicines with existing less costly alternatives;
- Establish an implementation group to drive the implementation of these measures.

### **Programme K – Care for the Elderly**

- The percentage of care costs under the Fair Deal Programme should not be increased as it is unfair on individuals and families. It has yet to be implemented and its success as measure to fund long-term care has yet to be proved.
- Criteria for eligibility for Home Care Packages should be clarified, however means-testing contradicts the central objective of the Scheme - to allow elderly people live independently for as long as possible in their own homes – and should not be introduced.

### **Detailed Paper 15 – Social and Family Affairs**

#### **Programme C – People of Working Age**

- The IMO believe that the Treatment Benefit Scheme should not be discontinued as it contributes significantly to the health of Irish citizens and the cost to the State in abolishing this scheme far outweighs the savings.
- The half-rate and full-rate carer's allowances should be increased not decreased, in support and recognition of the contribution made by carers.