NAGP

Cumann Naisiunta na nDochtuiri Teaghlaigh

NAGP SUBMISSION

TO THE JOINT COMMITTEE ON HEALTH

FEBRUARY 2, 2017

EXECUTIVE SUMMARY

The National Association of General Practitioners (NAGP) recognises the immense challenges faced in order to reform our health service. It is our opinion that an integrated care model will best serve the public with regards to clinical outcome, cost and sustainability. We believe that a decisive shift of resources and activity to primary care is possible and will create a better health service. The existing system is failing because it is orientated overwhelmingly towards expensive hospital care and dealing with episodic illnesses but fails to optimally manage the patients with chronic diseases, especially those with multiple chronic illnesses, whose numbers are rapidly increasing. The relocation of resources to community care will improve this situation dramatically.

To begin this, we must resource and address the capacity issue in General Practice. The Irish College of General Practitioners (ICGP) states that only one-third of general practitioner (GP) trainees intend to work in Ireland, less than half of these as full-time GPs. Rural and deprived inner city areas and single handed practices will bear the brunt of the resulting shortage of GPs, but no constituency will be unaffected. Next, we must improve the working conditions of GPs to increase retention of trainees and make Ireland attractive to GPs currently working overseas, as it as a competitive global market. There is an urgent need for a recruitment drive to attract Irish-trained GPs as well as Irish-trained practice and public health nurses back to Ireland.

The NAGP represents over 1,900 GPs. It is our mission to seek solutions to the problems in our health service, not only on behalf of our members but for society in general. We see the detrimental effects of the current broken system on our patients every week. Effective leadership and teamwork between senior clinical decision makers, management and Government will be the key to success.

Background

The Euro Health Consumer Index (EHCI), the most comprehensive measurement of healthcare systems internationally, ranks the Irish health service 21st out of 35 countries[1] and 29th for value. Irish hospitals are working at nearly full capacity – 93.8% compared to 84.3% in the UK and an OECD average of 77.3%[2]. Ireland spends at least 45% of our budget on inpatient care, placing us 5th from the bottom for efficiency.

International studies show that the strength of a country's primary care system is associated with improved population health outcomes, regardless of per capita health spend and percentage of elderly. The World Health Organization (WHO) has reported that increased availability of primary healthcare improves patient satisfaction and reduces aggregate healthcare spending. The majority of studies that compare services delivered by primary care show that it reduces costs, and increases patient satisfaction, with no adverse effect on quality of outcomes[3]. The evidence base for this is now beyond dispute.

GP-led primary care

The acute care sector cannot deal efficiently with the fastest-growing and most resource-hungry demographic, those patients with general fragility and multiple morbidities. A 2014 paper from the US Agency for Healthcare Research found that the costliest 1% of patients account for 22.7% of total expenditure[4]. Therefore, it is critical that we identify and proactively manage this cohort of patients, if we are to contain healthcare spending. The NAGP's proposals can achieve this, as borne out by international experience of comprehensive, GP-led primary care systems. Within the best of these systems, primary care acts as a 'hub', leading a clinical-community partnership between general practice, specialists, hospitals, home health, long-term care and other clinical providers. These networks focus on the needs of the individual patient, as well as those of populations and communities. GPs, provided with adequate resources and supports, can manage the majority of such patients, by facilitating coordination between the other branches of the system, including crisis prevention in addition to acute and chronic medical care.

The evidence for integrated care

The best example of the success of integrated healthcare comes from an actual scenario. The healthcare system in Canterbury, New Zealand, suffered a very significant loss of infrastructure and capacity following an earthquake in 2011. Health outcomes and resource utilisation were analysed pre- and post-earthquake using advanced statistical methods. The analysis, published in the *BMJ* in May 2016, found the following[5]:
"Canterbury's integrated health system transformations have resulted in a dramatic and sustained reduction in ED attendances and acute hospital admissions. This natural intervention experiment, triggered by an earthquake, demonstrated that integrated health systems with high-quality out-of-hospital care models are likely to curb growth successfully in acute hospital demand, nationally and internationally."

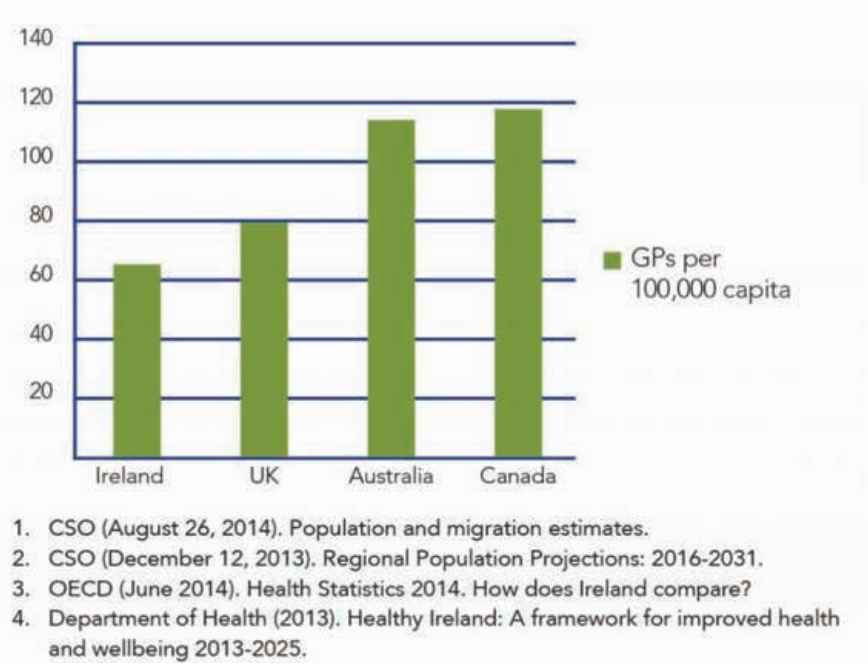
The interpreted time series analysis demonstrated that the rapidly-accelerated integrated Canterbury health system transformation strategy after the earthquake significantly lowered the level and the growth rate of acute admissions. These important shifts have significant resource implications. The most dramatic reduction in acute admissions growth after the earthquake occurred among those aged 65+ years. Canterbury's integrated health system model, which embodies community interventions including acute demand management services (ADMS), community rehabilitation enablement and support team (CREST), the medication management service (engaging community pharmacists to review medications actively) and the community falls prevention programme, targeted older adults. Unlike hospital avoidance programmes elsewhere, this targeting has been successful. ED attendance rates were also significantly influenced by the Canterbury health system's whole-system, community-focused approach.

Understanding the implications of this research is crucial. The NAGP, through its Primary Care Partnership, has direct access to the people who achieved this.

Challenges and solutions

The number of GPs in Ireland per head of population already falls significantly short of international norms.

Table 1: GPs per 100,000 capita population. Source: LHM Casey McGrath 2015[6].



General practice delivers 23 million consultations every year, projected to increase to 33 million within five years. The number of contacts provided by GPs is 10 times that of hospitals. The expansion in demand for GP services is due to facts: the increase in the number of Medical Card patients, now approaching 50% of the population since the introduction of the under-6s and over-70s schemes and the increase in the number of elderly frail and co-morbid patients. The table below shows the projected number of GPs needed to meet this demand.

Table 2: Projected number of GPs required. Source: LHM Casey McGrath 2015[6].

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

During this period of rising Medical Card numbers, Financial Emergency Measures in the Public Interest (FEMPI) has reduced the price paid per consultation by 33% against an ever-increasing cost base. GPs have disproportionately borne the burden of FEMPI, at enormous personal cost. This, however, is no longer sustainable, as the number of doctors leaving Ireland shows. Cashflow and poor working and contractual conditions make general practice an impossible choice for new graduates, many with large educational loans. The Department of Health must seek to address this urgently to stabilise and sustain general practice. If the Department of Health fails to do this, it will make the task of the NAGP in promoting reform all but impossible.

Retaining GP talent

It is the stated intention of 915 Irish GPs – almost one-third of the workforce – to retire or emigrate within the next three to five years, ie. within the lifetime of this Government. Such a drastic cut in available capacity in itself may be a significant challenge to creating a GP-led primary care system if immediate and meaningful improvement in the lives and prospects of GPs is not forthcoming.

Skilled generalists such as GPs are the cornerstone of medical care. With the increasing sub-specialisation of consultants and an ageing population with multiple illnesses this generalist role is crucial. The loss of a large proportion of such doctors will create a void that will be very difficult to fill, and planning to fill this imminent loss of GPs must begin quickly to avoid disaster.

There is a huge deficit in the resourcing of general practice. According to the Economic and Social Research Institute (ESRI), by 2021, four years from now, it is projected that Meath will have only 27 GPs per 100,000 population. Cork will have 63/100,000, Kildare and Laois will have little more than 30. Such a situation is just unconscionable, but on our current trajectory, inevitable.

Role of the NAGP

This is an historic moment. For the first time in 45 years, the State will engage collectively and comprehensively with general practice to determine the future of health delivery in primary care. It is a defining moment in the history of the Irish health system – one that can improve healthcare for patients for the next generation. The demographics of insatiable healthcare demand show clearly the need for a decisive shift to primary care and away from the overwhelmed hospital system. The negotiation of a new GMS contract therefore represents one of the greatest opportunities to radically improve our health service since the foundation of the State.

The NAGP is pleased that this historic shared journey has begun with the State and other representative bodies, to achieve a better health service for patients. The State assurance to the NAGP that it will have parity of process in these negotiations, with full and equal input into the new contract, equal to all other contributors, is vital for the successful conclusion of this decisive shift to primary care. We look forward to further engagement as equal partners for a shared future. A future that is focused on improving patient care for the 21st century with a resourced general practice playing its full part.

Priorities for a GP-led system of primary care

SUPPORT THE UTILISATION OF PRIMARY CARE TEAMS
Priority 1

Create a functioning primary care network. The NAGP supports the ICGP supported Local Integrated Care Committee (LICC) structure (based on the Carlow-Kilkenny model) which has been adapted by the Ireland East Hospital Group (IEHG) and adopted by the Primary Care Division. The LICC initiative proposes the creation of local clinical networks, comprising hospital consultants, primary care physicians and hospital/community management. We also recommend a re-designation of planned and existing primary care centres (PCCs) into primary care resource centres (PCRCs), to provide the infrastructure to house and expand the capabilities of the networks. We acknowledge that this may be not possible in some areas due to geographical and other issues. For primary care, and primary care teams (PCTs), to deliver there is a need for human, as well as physical, infrastructure to be developed. This means greater clinical staffing working in PCTs. Clinician-led projects drive hospital innovation. Similarly, GP-led primary care will do the same to integrated services in the community and at the interface with hospitals. There is now a choice to be made: do we continue to focus primarily on buildings or do we develop the human and professional engagements of PCTs in a way that allows all health practitioners and GPs to engage equally and efficiently? The NAGP is confident that there is little or no desire amongst its members to use these new centres as currently intended.

Primary care resource centres
We, therefore, recommend a re-designation of planned and existing primary care centres into primary care resource centres (PCRCs), to provide the infrastructure to house and expand the capabilities of the networks. Over the past year, the NAGP has engaged in wide-ranging consultations with clinicians and HSE management. The current PCCs only benefit a small number of GPs and patients. If re-designated as 'resource centres' they can serve as diagnostic and service hubs that support patient-focused care with full engagement of all local GPs. This model would mean that PCRCs in themselves may not always serve as locations for particular practices, but rather for all GPs/patients in a designated catchment area. If all GPs in a locality buy into the concept of one PCRC, this allows all to refer equally through one agreed pathway to podiatrists, dieticians, physiotherapy, occupational therapy, public health nurses, etc., expanding the clinical network and providing for oversight and budgetary control. While the NAGP recognises that this approach may not suit all locations, this is how controlled transfer of resources can happen in a planned way in most locations. Local and regional liaison among practices can be formalised. This would enable innovation and economies of scale for new developments. Supports for local integrated care would be accelerated, and patient outcomes improved. New PCRCs could have a significant role in developing social inclusion in healthcare, attracting engagement from mental health and addiction services, counselling (SHIP/CIPC), Traveller health and other voluntary services that are active in primary care. PCRCs could also be a focal point for local engagement with other State agencies – eg. Tusla, the Department of Education and Skills, and the Department of Arts, Heritage, Regional, Rural and Gaeltacht Affairs, etc.

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

Benefits of PCRCs:

- Puts the patient first;
- Changes the culture towards engagement;
- Solves the impasse on PCT development;
- Supports PCTs to deliver their full potential;
- Allows all GPs and health providers to engage with new PCRC buildings;
- Allows all GPs and patients equal access to PCRC facilities;
- Allows shared governance and development of PCRCs;
- Creates a service hub for all patients;
- Creates an agreed access point to develop local diagnostics;
- Builds community-based centres that can develop new services
- Develops and houses new integrated services with secondary care;
- Supports social inclusion in healthcare through community participation;
- Assists primary care to reach its potential for more care in the community; and
- Assists primary care to be more self-sufficient with less reliance on hospitals.

Practice manager subsidy

GPs operating in a single-handed practice are struggling to manage their increasing clinical demands along with the current level of administrative work required. Single-handed practices would benefit from a subsidy payment to finance a practice manager for administrative support.

The addition of a competent practice manager would allow GPs to focus on their clinical work, seeing more patients and ensuring adequate time for each appointment. We must ensure GPs' time is managed well. Supporting the work of GPs with the necessary administrative staff will ensure better outcomes for the patient and allow GPs to focus on the important work of patient care. With growing waiting lists nationwide to see GPs, both for urgent and routine appointments, such a simple measure would benefit many patients.

INCENTIVISE INWARD INVESTMENT
Priority 2

GPs, as independent contractors, have traditionally invested in their own practices and infrastructure. Since the financial crash, this has largely ceased, and there is a lack of economic confidence about inward investment. The NAGP would urge the Oireachtas Committee on the Future of Healthcare to explore the use of tax credits as a means of encouraging GPs to invest in their practices. Exploring the use of tax credits and reliefs, we believe, would create more financial certainty and contribute substantially to retaining doctors in Ireland.

SUPPORT INTEGRATED CARE
Priority 3

The NAGP supports the development of GP-led primary care and the shift of focus from our hospital-centric model to a community-based service. This requires a cultural as well as structural change. For primary care to engage as equals with secondary care, it needs a forum for local and regional engagement. The NAGP Local Integrated Care Committee (LICC) structure can provide this within a relatively short timeframe.

SUPPORT DIGITAL HEALTH SOLUTIONS
Priority 4

Integrated health means patient-centred health. The cultural emphasis on medical practice must move away from institutions and employees and towards the needs of the patient. The creation of a human and digital network that allows universal, real-time access to relevant information is vital to achieving this, with IT playing a key role.

Within the professional sphere of services surrounding the patient, communication and coordination can then begin. Problems can be better identified and appropriate action taken at the most practical level. Video technology, data and calendar sharing will enable clinical networks to react quickly, increase productivity, reduce duplication, and avoid missed appointments. The NAGP will have such a platform in operation in the coming months, and would be willing to work with the Department of Health to use the platform as a model for expansion. A unique patient identifier system is essential, and we welcomed its introduction last year.

BUILD THE NURSING INFRASTRUCTURE WITHIN GP LED PRIMARY CARE
Priority 5

As we move towards less hospital-centric care there is a need to develop the nursing capacity in general practice to assist in new models of care for chronic disease. An ageing, multimorbid population, with complex socio-medical needs, requires greater levels of anticipatory, predictive and preventative care that can only be delivered by "generalists" in the community. This is where GP-led care can provide better care and cost savings to the state. The move from specialism to generalist will take time, but should be resourced by the recruitment of extra nursing staff within general practice. We are seeking for the current number of practice nurses to at least double in order to reach the level that is in keeping with ratios of GPs per practice nurses in other successful GP-led primary care systems. Some of these additional nursing posts can support chronic disease management in the community using existing agreed clinical care programmes. The addition of extra primary care nurses would assist, to some extent, the difficulty this country will face in enticing GPs back to our shores.

Existing GP practice nurses will need training in delivering the new services necessary in a GP-led primary care system. Nurses should be trained to work independently with the support of a GP, to reduce demand on the GP workforce and allow doctors to focus on the intensive management of individuals and population groups.

DEVELOP COMMUNITY-BASED DIAGNOSTICS
Priority 6

For primary care to deliver its full potential, it must learn to work seamlessly with secondary care through new structures such as LICCs, community healthcare organisations (CHOs) and hospital groups (HGs), and also develop its own autonomous diagnostic services that are based in the community and not in the hospital.

The beneficial synergies for primary care and hospitals are evident from diagnostics delivered at PCRCs. Having a diagnostic hub at the local level would break the dependence on hospitals and make secondary care and primary care more efficient.

SUPPORT CHRONIC DISEASE MANAGEMENT IN THE COMMUNITY – NOT IN HOSPITALS
Priority 7

The new GP contract must provide for chronic illness and multimorbidity management, on an agreed and not ad hoc basis. We need to put in place a five-year transition programme to move chronic disease management from the acute hospital setting into primary care. Flexible care pathways can be delivered by GP-led Primary Care that works through LICCs with its partners in hospitals, HGs and CHOs. A decisive shift to primary care can only happen by agreement and adequate resourcing. Clarity of responsibility must be central to any new GP contract. The NAGP will play its full part in the negotiation and implementation of effective chronic disease management.

SUPPORT DIRECT GP ACCESS TO HOSPITAL SERVICES
Priority 8

As we move towards more seamless care between primary care and secondary care there is a need for GPs (who are the senior decision makers in the community) to have direct access to some agreed hospital services. Direct GP access to medical assessment units, acute surgical assessment units, gynaecology, geriatric, paediatric and other speciality services are critical in chronic care management but are not generally accessible to GPs outside of the medical and surgical specialities. Rapid access clinics for frail elderly are a top priority, especially as we experience a winter of predictable respiratory illness in this cohort each year, many of whom will end up needlessly in emergency departments.

Swift discharge of patients from hospital should be facilitated by primary care to avoid delayed discharges – a major cause for rising trolley counts. Home-care packages should be prioritised by primary care and ideally come under the Fair Deal scheme by statute. LICCs should be active in improving access to our acute hospitals and facilitating early discharge.

References

1. *http://www.healthpowerhouse.com/files/EHCI_2015/EHCI_2015_report.pdf*
2. *http://www.oecd.org/health/health-data.htm*
3. *http://www.modernhealthcare.com/article/20141008/NEWS/310089966*
4. *https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-annual-review-evidence-2013-2014*
5. *http://bmjopen.bmj.com/content/6/5/e010709.full*
6. *LHM Casey McGrath Report 2015*

Additional resources

- The quest for integrated health and social care: A case study in Canterbury, New Zealand *(http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf)*
- Mrs Andrews' Story – what went wrong? Health Service Journal *(https://www.youtube.com/watch?v=I0TVbhHdg4A&feature=youtu.be)*

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