ICGP Opening Statement

The ICGP thanks the Chair and Members of the Joint Committee on Health for the invitation to discuss prescription pattern monitoring and the audit of usage and effectiveness trends for prescribed medications.

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Prescribing is a key professional activity for General Practitioners- it is estimated that a prescription is generated in two out of every three consultations. It is GPs who reconcile and coordinate patient's medications as they transition between different healthcare interfaces. It is GPs who issue repeat prescriptions for the Irish population. It is GPs who are best placed to share decisions with patients on medications, factoring their preferences on the possible benefits the possible harms. Monitoring the usage, the effectiveness and trends for prescribed medications are essential, for a high quality healthcare system. This submission is composed of four sections:

The first section outlines the **context** to prescribing trends in the Irish healthcare system:

- The prevalence of chronic diseases and multimorbidity is increasing in Irish society, though is not reflected in a modern GP contract.
- Rising prevalence of chronic diseases and an ageing population has resulted in a rise in the dispensing and costs of medications in the annual health budget. Our submission outlines our expenditure on pharmaceutical products, but in summary we spend approximately **€2 billion** on medications, which is taken from the community budget.
- In contrast to the drug budget, Irish General Practice is extremely poorly resourced. We spend < 4.5% of our overall healthcare budget on General Practice. At a time when GP-led, community-orientated healthcare should have happened, we have seen a massive retraction in GP funding. FEMPI cuts

are still imposed on General Practice, which limit time for patient care. We work off a 40 year-old, out-dated contract. We have severe capacity restraints, with 6.2 GPs per 10,000 population (lowest in Europe) and an exodus of our GP graduates.

- GPs coordinate and facilitate high-quality repeat prescribing for patients. GPs issue a 'repeat-script' every three-six months, but this can be more frequently if there is a clinical need. Whilst the GP takes the responsibility and assumes the risk for prescribing, often GPs are not the original doctor who starts a medication. If a drug is initiated in hospital, the GP would issue the prescription on a GMS script for a GMS-eligible patient- the cost then comes from the community budget.
- ICGP supports evidence-based and cost-effective treatments in the Irish healthcare setting (including prescribing). ICGP also supports initiatives from the Medicines Management Programme to support effective prescribing. Opportunity costs are evidence throughout the healthcare system, where we spend money on low value products (with limited benefit and excessive costs), which results in other areas of our public healthcare system being under-funded.

The second section outlines the evidence for trends in prescribing:

- Evidence from large, population-based studies have shown that prescribing of 10 of more drugs (called 'excessive polypharmacy'), in Over-65s, has increased from 2% in 1997 to 22% in 2012.
    - Whilst prescribing has increased, the odds of 'Potentially Inappropriate Prescribing' in 2012 (versus 1997)- having controlled for age and level of polypharmacy- was 60% less.
    - GPs and hospitals are prescribing more medications for an ageing and more multimorbid population, but are doing a better job at prescribing.
- The submission also looks at research from Irish cohort studies, including TILDA. One report has shown that in an older population reporting polypharmacy, using a system of reference pricing based on groups of similar drugs could potentially save up to **€152.4 million** per year.
- The submission then addresses trends in the prescribing of certain drug classes, including benzodiazepines, anti-depressants, opioids and antibiotics.
    - We can discuss the prescribing trends in more detail in the Questions and Answers session, but we might anti-depressant prescribing now.
    - In 2016, the State spent €40.07 million on anti-depressant medications for GMS eligible patients and €4.29 million on the Drug Payment Scheme.
    - In contrast, we spent ~€10 million Counselling in Primary Care was only.

    - All the evidence suggests that GPs prescribe extremely appropriately in the context of a severe capacity shortage in General Practice and Primary Care.
    - Prescribing rates of anti-depressants reflect a lack of psychological therapies and a lack of social therapies and resources in society (including fragmented communities, isolation and austerity).

The third section discusses some opportunities and challenges in relation to audit and data monitoring:

- We outline how it is pivotal that GPs are provided with sufficient time and resources to enable shared discussion on medicines management.
- When savings are made, it is of paramount importance, that savings are directed in appropriately funding Irish General Practice.
- We need to address the challenge of medicines reconciliation across healthcare interfaces and promote electronic discharges, to reduce error and improve quality.
- The role of clinical pharmacists in the General Practice team (or in the nursing home setting) should be explored, but as part of a new GP contract.
- Monitoring and audit of prescribing, if done correctly, has the potential to be an extremely powerful tool for GPs in their on-going efforts to deliver the very best care for their patients.
    - Research and audit needs to be actively supported and promoted at the highest level.
    - We need to be careful, when using this data or when comparing raw prescribing data from individuals and comparing it to national standards. We need to take account of confounders such as poverty and deprivation, or conditions such as multimorbidity and depression.
    - Continuous Medical Education has seen a curtailment in funding, which needs to be reversed.
- Pharmaceutical advertising- in the national media- indirectly promoting certain products, has been an unwelcome development in recent years. This should come under legislative control as GPs are encountering demand for drugs and services, which have dubious cost-benefit.

Lastly, the submission finishes with some recommendations, including:

- GPs need **time** to deal with complex cases. This will require a modern GP contract which facilitates the management of chronic conditions and medication management. Before this, there is need for the urgent reversal of FEMPI, which has curtailed the ability of General Practices to grow, at a time when GP services should expand. We also need to retain our brightest and

best GPs who see other healthcare systems as a preferable career option. ICGP is becoming increasingly frustrated with the lack of government action on these key matters.

- We need to direct any savings in drug prescribing back into General Practice to reinforce a cycle, which is to the benefit of the patient and of the health system more widely.
- A medicines management programme, led by GPs, needs to be created as part of a new contract.
- This committee should endorse a recommendation to ban non-governmental healthcare advertising, especially the indirect promotion of drugs in the media.
- The ICGP is willing to continue to work and collaborate with the HSE and educational bodies to promote cost-effective, evidence-based prescribing. Sometimes collaboration has not happened (e.g. such as through online requirements for issuing certain drugs or for phased prescribing), which has disenfranchised and increased frustration with GPs.
- Prescribing trends can only be identified through research and audit. Academic career structures for GPs have not been sufficiently facilitated by the HSE or the Department of Health. Similarly research on our electronic health records- such as that through the Irish Primary Care Research Network- is underdeveloped in the Irish setting, which will require an expansion and State funding. This will deliver savings in the future.