GPs and the Irish primary care system: towards Universal Primary Care?

No.1 of 2014

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Editorial

Universal Primary Care (UPC) is a key Programme for Government commitment. Proposals involve the establishment of a primary care system which is free at the point of use, based on multi-disciplinary teams in dedicated centres, and with greater focus on the care of chronic conditions. The stated rationale of this and wider health reforms is to end the 'unfair, unequal and inefficient two-tier health system'.

Although primary care involves a range of health professionals, general practitioners (GPs) are currently the lynchpin of the system. This *Spotlight* provides an overview of the current role of GPs in the Irish primary care system, including eligibility for free or subsidised care, data on workforce supply, practice organisation and GP remuneration. Irish developments are also put in the context of wider comparative primary care provision.

The *Spotlight* also looks at some key GP related issues around providing UPC, including resource and infrastructural challenges, GP supply issues, remuneration, and access and efficiency.

27th March 2014
Library & Research Service
Central Enquiry Desk: 618 4701/4702

Summary

Reform of primary care has been on the policy agenda for well over a decade, reflecting perceptions that strong primary care is fundamental to overall health system functioning. Broadly, the comparative evidence supports this, although recent research suggests that achieving strong primary care may increase rather than reduce health expenditures, in the short term at any rate.

Key features of strong primary care are that it be 'people-centred, accessible and comprehensive, offer continuity of care and provide a regular entry to the health system'.[1] Primary care varies a lot across countries – given that, the role of GPs in Irish primary care is in line with provision elsewhere in many respects. Private practice, small or solo practices, GP gatekeeping, and other aspects of provision are widespread. However, the comparative evidence indicates that Irish primary care falls short of European norms in at least one major respect – that of universal access to free or heavily subsidised GP care.

There are various possible paths to better access – some countries achieve this through keeping co-payments low by various means, or (as proposed by the current government) through entirely free access for all. Achieving free GP care for all presents clear challenges, as do other GP related aspects of Universal Primary Care proposals.

The biggest immediate challenge surrounds how GPs might be paid to provide care which is 'free at the point of use'. The chosen method will replace existing GP income from private patients - currently around 60% of the population. Decisions made in relation to the proposed initial phase of free GP care for under sixes may be seen as providing the template for future phases of reform. Both the comparative and the Irish historical evidence suggest that GPs will have very strong positions on remuneration.

There is broad consensus that different GP payment methods provide financial incentives of varying kinds to providers e.g. to contain costs, or increase productivity, or reduce levels of services. They may provide incentives to patients too e.g. whether to seek care from their GP or their local hospital, with possible implications for the wider health service.

GP remuneration is a complex area with trade-offs between different methods, and varying levels of evidence and evaluation for specific payment methods. Additionally, it can be difficult to tell how well or badly GPs are paid in comparative terms. OECD data suggests that Irish GPs are well remunerated relative to GPs in other countries, but the data may need some improvement, and the most recent is for 2011. GPs and their stakeholders have stated that GPs and their practices are under resourced and struggling financially. Other challenges include:

GP supply: there is a potential shortfall and geographical disparities in the supply of GPs. This may be especially problematic if free GP care increases demand;

Infrastructure: current proposals rest on the provision of Primary Care Teams and this is proving slow and challenging to achieve;

Wider range of service provision: proposals for better chronic care management and health promotion gives GPs a larger role, and there is debate about both the rationale for this, and the capacity to achieve it with current resources.

Reforming primary care in Ireland

What is primary care?

Primary care has been defined as 'the range of services between informal care and hospital care'.2 It is generally the first point of contact people have with the health system, and in most cases, that first point of contact is with a General Practitioner (GP). While GPs are central to primary care, provision may also involve a range of other health care professionals such as nurses, physiotherapists, occupational

[1] Masseria, C., Irwin, R., Thomson, S., Gemmill, M., and Mossialos, E. (2009) *Primary Care in Europe* European Commission DG Employment, Social Affairs and Equal Opportunities, p. 3.

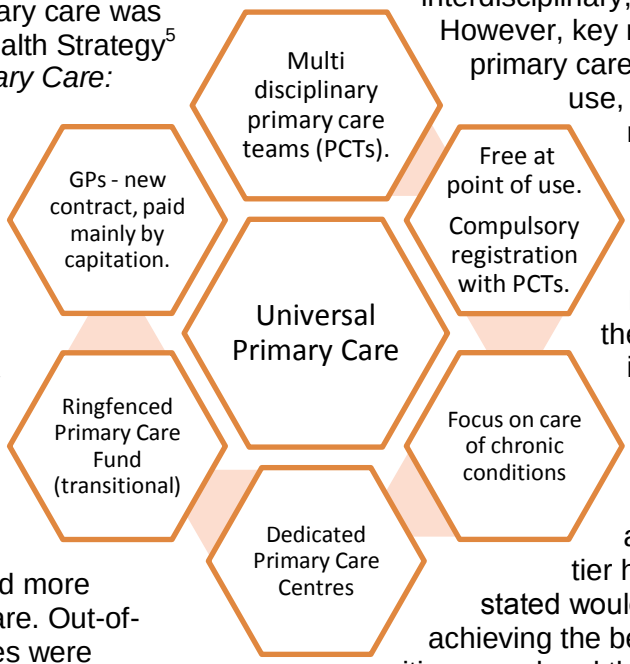
[2] Boerma. (2006) cited in Masseria, *et al* (2009) op.cit. p. 3.

therapists, speech and language therapists and others.

Health systems currently face many challenges, including ageing populations, rising health care expenditures, increasingly complex needs, new risks, and health inequalities.[3] In the face of these challenges, strong and effective primary care systems are widely seen as a key way of improving overall health system performance.[4]

Proposals for reform in Ireland

Substantial reform of primary care was outlined in 2001 in the Health Strategy[5] and in more detail in *Primary Care: A New Direction*.[6] The stated motivation for change was that the primary care infrastructure was poorly developed. Services were fragmented, with little teamwork, and there was limited availability of many professional groups. Liaison between primary and secondary care was often poor and many services provided in hospitals could be provided more appropriately in primary care. Out-of-hours primary care services were underdeveloped.[7]



Primary care teams

The Strategy proposed an inter-disciplinary approach to primary care, based around primary care teams (PCTs).[8] PCTs would comprise a wide range of health professionals, located in a single primary care centre, each serving a population of 3,000 to 7,000 (subsequently revised to approximately 8,000).[9] It was envisioned that 400-600 of these teams (two-thirds of the full requirement) would be established by 2011.[10] PCTs would be supported by wider primary care networks, including pharmacists, dieticians, speech and language therapists, and other professionals.

'Free' primary care

Subsequently, the achievement of Universal Primary Care (UPC) was a key Programme for Government commitment.[11] The proposed UPC system would be team-based and interdisciplinary, as previously envisioned. However, key new elements were that primary care would be free at the point of use, involve compulsory registration with a PCT, and be funded and organised in tandem with wider proposals for health reform based on Universal Health Insurance. Broad elements of the proposed UPC structure are illustrated in the figure beside.

UPC proposals are one component of wide-ranging health reforms aimed at achieving a universal, single tier health service which it is stated would 'reduce the cost of achieving the best health outcomes for our citizens and end the unfair, unequal and inefficient two-tier health system.' [12] Primary care reform is described as the first phase of this reform programme, with the successful introduction of UHI the second phase.[13]

Key actions towards UPC

In November 2012, key actions towards both UHI and UPC were sketched out in *Future Health.*[14] A Universal Primary Care project team

[3] Kringos, D. *et al* (2013a) 'The Strength of Primary Care in Europe: an international comparative study' *British Journal of General Practice* November 2013.
[4] Kringos. *et al* (2013a) op.cit.; Department of Health (2001) *Primary Care: A New Direction*
[5] *Quality and Fairness - A Health System for You*
[6] Department of Health. (2001) op.cit.
[7] ibid.
[8] Curry, J. (2011) *Irish Social Services*, Dublin: IPA
[9] Houses of the Oireachtas. (February 2010) Joint Committee on Health and Children. *Report on Primary Medical Care in the Community.*
[10] The long-term projection was for 600-1,000 based on the 2001 population. The projected number of teams due by 2011 was reset to 527 in 2010: Comptroller and Auditor General (2010) *Accounts of the Public Services 2010 Vote Managemen: Report of the Comptroller and Auditor General Volume 2*; p. 575.
[11] Programme for Government
[12] ibid.
[13] Future Health - A Strategic Framework for Reform of the Health Service 2012 – 2015
[14] ibid.

has been established to drive a number of key projects to establish UPC on a phased basis.[15]

Amongst these actions is the introduction of legislation on a phased basis to extend GP care without fees. The *Health (General Practitioner Medical Service) Bill (*currently on the legislative program but unpublished at time of writing) aims to extend free GP care to children under six. In January 2014, the HSE published a new draft GP contract for the provision of services to children under six, and a consultation on this concluded on February 21st. In parallel with this the Department of Health and the HSE are developing a fees structure to underpin the proposed legislation.[16] The draft contract has been the focus of substantial critical comment by GPs and their representative bodies, and is discussed further below.

GPs in the primary care system

Current structure of primary care: GP practices

GPs lie at the heart of the primary care system and it has been estimated that there are approximately 14 million visits to GPs annually, compared to 6.3 million hospital visits.[17] The role of the GP is not limited to seeing, diagnosing and treating patients. A key part of their role is to act as 'gatekeepers' to secondary or specialist care. As discussed further below, one rationale for proposed reforms is that better resourced inter-disciplinary teams may reduce referrals to secondary care.

Strong and effective primary care requires clarity around the governance and management of the referral pathway. A 2011 HIQA report made a number of recommendations in relation to this, but this aspect of primary care is not examined here.[18]

Data on the structure of GP practices are poor. However, small or solo practices appear to be the most common form of provision. A 2006 survey[19] found that:

- While only 35% of GPs worked in single-handed GP practices, over 60% worked either in single-handed practices or with just another GP;
- Fewer than 20% worked with more than four GP colleagues in the same practice;
- Over 70% of practices employed a nurse on a part-time or full-time basis;

The limited evidence suggests that 'it is still rare for GPs to work alongside other health professionals to provide an integrated primary care system.'[20]

Eligibility for primary care

The complex eligibility criteria for primary care is one of the key distinguishing features of the Irish primary care system. A 2012 Report commissioned by the Department of Health from the European Observatory on Health Systems and Policies (referred to hereafter as the European Observatory Report) reviewed the policy options open to the Irish government in responding to the effects of the financial crisis on the Irish health system.[21]

The Report pointed to gaps in health system coverage and cost coverage which distinguished Ireland from other EU countries, particularly for GP services.[22] It stated that Ireland is the only EU health system that does not offer universal coverage for primary care. As the Report notes, statutory entitlements to health care in Ireland are complex. This is particularly the case in relation to primary care. Some 43% of the population receive free or subsidised primary care via a medical card or GP visit card (see table 1). (Full details on medical card eligibility

[15] ibid.
[16] Statement by Mr. Alex White T.D., Minister of State for Primary Care Consultation, January 31 2014.
[17] Teljeur, C., Tyrell, E., Kelly, A., and O'Dowd, T. (2013) 'Getting a handle on the general practice workforce in Ireland', *Irish Journal of Medical Science* July 2013.
[18] HIQA. (March 2011) Report and Recommendations in Patient Referrals from General Practice to Outpatient and Radiology Services, including the National Standard for Patient Referral Information
[19] O'Kelly, F., O'Kelly, M., and O'Dowd, M. (2006) *Structure of General Practice in Ireland 1982-2005*, ICGP/TCD cited in Thomas, S. and Layte, R. (2009) 'General Practioner Care' in Layte, R. *et al* (eds) *Projecting the Impact of Demographic Change on the Demand for and Delivery of Health Care in Ireland* Dublin: ESRI
[20] Thomas and Layte. (2009) op.cit., p.46.
[21] Thomson *et al.* (2012) op.cit.
[22] Thomson, S. Jowett, M., and Mladovsky P. (2012) Health System Responses to financial pressures in Ireland: policy options in an international context

criteria and trends are available from an L&RS Note on the subject.)

Those who are not eligible for a medical or GP card pay for their own visits to GPs, either out of pocket, or in some cases with reimbursement from their private health insurance (PHI) policies.[23]

Table 1: Coverage for GP consultations in Ireland

Type of cover	Cost of GP consultation to patient
Full medical card	Free
GP visit card	Free
PHI with GP coverage	Full cost at point of use, with full or partial reimbursement by PHI
PHI without GP coverage	Full cost at point of use
No cover	Full cost at point of use.

Source: adapted from Layte and Nolan (2013)[24]

It has been suggested that the eligibility structure and the associated remuneration of GPs have a range of potentially adverse effects on the behaviour of both patients and GPs. In particular, they create financial barriers to access for some, which may result in unmet need for health care.[25] It may also be the case that undesirable incentives for GPs result, particularly from the fact that they are remunerated in two very different ways.

Paying for primary care: GP remuneration

The eligibility structures outlined above mean that GPs are currently remunerated in two main ways - via the Primary Care Reimbursement Service (PCRS) for services to those who are covered by medical or GP visit cards under the General Medical Services (GMS); and via fees for consultation from private patients. The GMS scheme dates from the *Health Act 1970*. Previously, those eligible for State funded primary care received this at public dispensaries, where they had no choice of doctor. The dispensary system had its origins in the *Poor Relief (Ireland) Act 1851*, and dispensary care for the sick poor was provided by a network of salaried part-time doctors (District Medical Officers).[26] The *Health Act 1970* allowed public patients to choose their doctor, and also to see them at the same surgery as private fee-paying patients: it is often known in shorthand terms as the 'choice of doctor scheme'.[27]

Primary Care Reimbursement Service (PCRS) payments to GPs

GPs receive a range of fees and allowances under the GMS scheme. The key payment is the annual 'capitation' payment in respect of each medical card and GP visit card patient on their list. This payment is weighted for age and gender to reflect differential risks in need for healthcare.[28] Additionally, there are allowances for such things as out-of-hours fees, a rural practice allowance, a remote area payment and a range of other allowances.[29] The GMS payment has been described as 'highly valued by GPs because it is superannuated and attracts staffing subsidies.'[30]

In addition to the GMS payments, a number of doctors who are not contracted to the GMS scheme receive payments for various national primary care schemes.[31] In 2012 fees to GPs were €351m and and allowances were €132m, or €483.14m total (Table 2). Capitation payments account for just over 52% of GP payments under the GMS.[32]

Note that the total PCRS cost includes a range of other payments, the largest proportion of

[23] There is a monthly cap (currently €144) on pharmaceuticals under the Drugs Payment Scheme, and tax relief on some medical expenses for this category also.

[24] Layte, R. and Nolan, A. (2013) 'Health, Eligibility and the Utilisation of GP Services' Presentation to *Growing Up in Ireland* Research Conference, 27 November 2013, Croke Park

[25] Thomson *et al*. (2012) op.cit.

[26] Irish College of General Practitioners (2007) History of the GMS; Curry. (2011) op.cit.

[27] Curry. (2011) op. cit.

[28] Seven GPs continue to provide service under a fee-per-item of service agreement.

[29] PCRS (2013) *Statistical Analysis of Claims and Payments 2012* Dublin: HSE

[30] Teljeur, C., Kelly, A.,and O'Dowd, T., (2011) 'Spatial Variation in General Medical Services Income in Dublin General Practitioners' *International Journal of Family Medicine* Volume 2011

[31] Some 468 doctors not contracted to GMS scheme provide services such as Primary Childhood Immunisation Scheme, Methadone Treatment Scheme, National Cancer Screening Service and other such schemes.

[32] L&RS calculation, data from PCRS. (2013) p. 72.

which is accounted for by drugs and medicines for both GMS and non GMS patients.[33]

Table 2: PCRS payments to GPs, 2011 and 2012

Payments	2012 €m	2011 €m
GP Fees	351.09	342.93
GP allowances	132.05	126.43
Total GP payments	483.14	469.36
Total PCRS	2,558.18	2,427.45

Source: PCRS (2013)

The average GP cost per eligible person in the GMS scheme was €243.40 in 2012, a reduction of 5.6% from 2011. There is substantial variation in the average GP cost per person by HSE region and local health office, from a low of €88.83 per person in Dublin West to a high of €384.75 in Dublin South. This reflects the different age structures of the respective populations (capitation payments are weighted by age) and differences in GP numbers.[34]

The fees paid to GPs under the GMS have been reduced on a number of occasions. Most recently, in July 2013, the fees paid to general practitioners under the *Financial Emergency Measures in the Public Interest (FEMPI) Act, 2009* were reduced overall by 7.5% via a range of diverse methods.[35]

Price of a GP visit

Data on GP fees are not routinely collected. A Competition Authority informal price check in 2008 suggested that the cost of GP fees in urban areas was around €50-€55 and slightly lower in rural areas.[36] More recently, an online survey of 501 parents (with private health insurance) by Laya Healthcare in 2012 found that the national average cost of going to see the doctor was €46.26, rising to a high of €53.29 in Dublin.[37]

It has also been noted that charges are complicated by uncertainty about pricing level, with charges varying by GP, and also by visit. Patients may find it hard to predict in advance how much a visit may cost them.[38]

The Irish Medical Organisation (IMO) has stated that GP survey data indicate that income from private practice has been severely reduced in recent years.[39]

The GP workforce: supply and trends

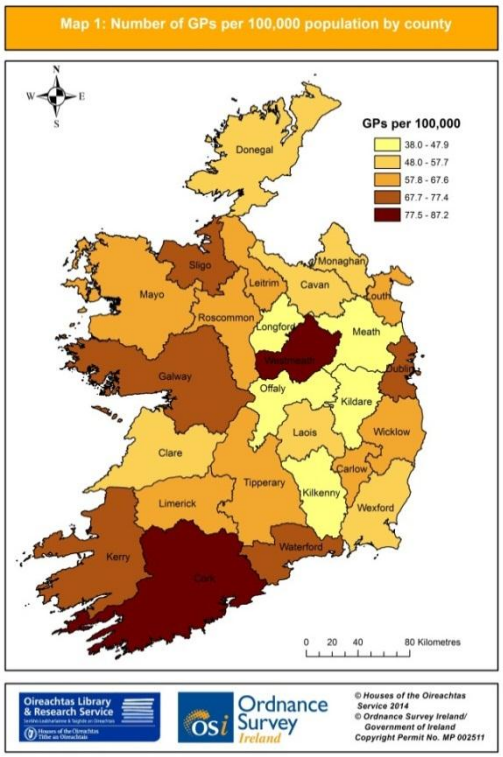
It is difficult to track the precise number of GPs in Ireland, as there is no centralised register of practicing GPs.[40] There are two main sources of information, however both have problematic aspects.

One source is the numbers on the Medical Council's Register of Medical Practitioners (2,840 at end 2013).[41] However, not all GPs who are registered are necessarily active in practice. Consequently, it is also possible to look at the numbers who hold a GMS contract (2,413 on the same date). However, this does not necessarily include all practising GPs. Data is also held by the Irish College of General Practitioners (ICGP) (2560 at end 2013), but this is also not inclusive of all GPs.[42]

A recent (2013) study used a number of different sources to try and estimate the number of GPs.[43] The authors estimate was that there were 2,954 GPs, equivalent to 64.4 per 100,000. This is about 15% greater than previous estimates. They also found substantial regional variation, ranging from 38 per 100,000 in Meath to 87 per 100,000 in Westmeath (see Map 1 over).

[33] It includes the Drug Payment Scheme -see footnote 23.
[34] Hence variations in associated payments for practice support, leave, superannuation and so on.
[35] Details are available at: http://www.dohc.ie/press/releases/2013/20130702b.html
[36] Competition Authority. (2009) *Competition in Professional Services General Medical Practitioners Part I: Overview of the GP Profession* Dublin: The Competition Authority
[37] 'GP fees in Dublin are the most expensive in the country' *The Journal*, August 31 2013.
[38] Smith, S. (2009) 'The Irish 'health basket': an international perspective' *ESRI Research Bulletin* 2009/4/4
[39] 'A profession in crisis' *Irish Medical News* 20 June 2011
[40] Teljeur *et al*. (2013) op.cit.
[41] The numbers who held registration in the specialty of General Practice on the Specialist Division of the Register. Reply of the Minister of State at the Department of Health, Alex White T.D. to PQ Ref. 587 11/03/2014.
[42] The ICGP estimate that approximately 90% of GPs in Ireland are registered with them (OECD Health Data 2013).
[43] Teljeur *et al*. (2013) op.cit.

The research suggested a deficit in a ring of counties, including Meath, Kildare, Offaly and Longford. The authors suggested that lower numbers in commuter-belt counties may reflect greater utilisation closer to where people work – as GPs are self-employed they tend to distribute where there is demand for services.[44]



Source: compiled by L&RS using data from Teljeur *et al* 2013.

Additionally, the need for primary care may vary from one area to another – for example, there is strong evidence that primary care utilisation is higher in deprived areas.[45] Research suggests that while access in deprived areas in cities in Ireland is generally good, GP practices in some highly deprived urban areas may be overstretched.[46] As well, rural populations in Ireland are dispersed, and 'for a GP to achieve a large enough population catchment to run a viable practice, the catchment will have to encompass a large geographic area'.[47]

[44] ibid.
[45] Teljeur, C., O'Dowd, T., Thomas, S., and Kelly, A. (2010a) 'The distribution of GPs in Ireland in relation to deprivation' *Health and Place* 16, pp.1077-1083.
[46] ibid.
[47] ibid. p.1081.

A 2010 study of GP workforce planning[48] pointed to a range of other trends such as:

- Increasing number of female GPs: 44% of the workforce was female in 2010, compared to 15% in the early 1990s.
- The mean age of the GP workforce is 47.8 years;
- A declining proportion of GPs working in rural areas (33% in early 1990s to 22% in 2005);
- A growing preference for flexible hours and early retirement;
- An increase in the numbers holding vocational training;

Many of these trends are endorsed by a Medical Council 2012 survey of doctors retaining registration.[49] In particular, some 22% of GPs who responded reported working part-time (in an average week).[50]

The impact of these trends are returned to later in the *Spotlight*.

Primary care: comparative perspective

What is the benefit of strong primary care systems?

Strong and effective primary care is seen as fundamental to overall health system performance, as recent research endorses. An EU-funded project on primary care in Europe (PHAMEU[51]) compared primary care systems in 31 European countries. Researchers from the study[52] found that strong primary care was associated with better population health, lower

[48] Teljeur, C., Thomas, S., O'Kelly, F., and O'Dowd, T. (2010b) 'General practitioner workforce planning: assessment of four policy directions' BMC Health Services Research, 10: 148.
[49] Medical Council. (2013) Medical Workforce Intelligence Report. In 2012 doctors seeking to retain their registration were asked some additional questions, to which most responded.
[50] The questionnaire asked which single category (full-time, part-time or other) best described their current practice of medicine in an average week.
[51] Primary Health Care Activity Monitor for Europe (PHAMEU).
[52] Kringos, D *et al*. 2013b 'Europe's Strong Primary Care Systems are linked to Better population health but also to Higher Spending' *Health Affairs* 2013 32(4) 686-694

rates of unnecessary hospitalizations, and relatively lower socioeconomic inequality. Previous studies found that countries with strong primary care spent less on health care.[53] However, the PHAMEU study found that:

> 'Overall health expenditures were higher in countries with stronger primary care structures, perhaps because maintaining strong primary care structures is costly and promotes developments such as decentralization of services delivery.'

However, there was also evidence that comprehensive primary care was associated with slower rates of growth in health care spending. This may imply that initial higher rates of spending might lead to longer-term savings.[54] Further research on the relationship with spending levels and growth was recommended.

What makes a strong primary care system?
Key features of strong primary care are that it be 'people-centred, accessible and comprehensive, offer continuity of care and provide a regular entry to the health system'.[55] In the PHAMEU study, countries found to have strong primary care systems include Estonia, Finland, Denmark, Lithuania, Netherlands, Portugal, Slovenia, Spain and the UK. Irish primary care was judged to be weak.

The study highlighted some similarities among countries with strong primary care systems, including two key elements:

- Pre-eminence of GPs as the key focal point of primary care provision – duties included being the main point of entry, taking a medical advocacy role, and coordinating patient care (in diverse ways however); and

A formal commitment to universal access to primary care. The study noted that all countries with the exception of Cyprus, Ireland and Latvia tended to lower primary care co-payments as much as possible particularly for general practice visits, (though there was more variation for pharmaceutical cost sharing). The data on which these conclusions are based are complex because there is substantial variation in how primary care is organised and financed across the EU and the OECD.[56]

The PHAMEU study compared systems along seven core dimensions (see Table 3), comprising 77 separate indicators. These were broadly divided between structural dimensions, and process or service delivery dimensions. Countries were scored on each indicator leading to a score for each for the 7 dimensions and an overall score. The authors note that the research was reliant on expert opinion for some of the data collection, which may influence the results.

Table 3 (over) summarises the dimensions studied, and also indicates the wide range along which primary care can vary. The Table also summarises the specific findings for Ireland

Comparing selected dimensions

This section looks at selected dimensions of primary care, chosen because they were deemed particularly relevant to the focus of this *Spotlight* - practice organisation, number and remuneration of GPs, and barriers to access.

How are practices organised?
There are many ways in which practice organisation varies internationally. Practices can be public or private, and group or solo. Registration with a GP may be required, or not. And there is also variation in the 'gatekeeping' role of GPs in terms of whether or not they control access to specialists.

A 2009 OECD survey[57] found that primary care is predominantly private (21 countries) and of these, solo practice was the most common (12 countries). Group practice, however, was the predominant mode of provision in 9 of these 21 countries. In 9 counties, primary care services were mainly provided in public health centres.

Edwards *et al* (2013) point to some benefits of small practices in terms of continuity of care.[58]

[53] See summary discussion in Kringos *et al* (2013b). Also Edwards, N., Smith, J., and Rosen, R. (2013) *The primary care paradox – New designs and models* KPMG/Nuffield Trust
[54] Edwards *et al.* (2013) op.cit.
[55] Masseria *et al.* (2009) op.cit., p.3.
[56] Masseria *et al*. (2009) op.cit. Kringos D. *et al* (2013a)
[57] Kringos *et al.* (2013a) op.cit.
[58] Edwards *et al*. (2013) op.cit.

Table 3: Comparing primary care dimensions (PHAMEU study)		
Primary Care Structure		
Dimensions	**Description**	**Ireland**
Governance	System goals, equity in access policies, collaboration policies, (de)Centralisation, quality management, patient advocacy (12 indicators)	Weak
Economic conditions	PC expenditures, employment status, coverage, remuneration system, and income of PC workers (11 indicators)	Weak
Workforce development	Profile of the PC workforce, professional status, supply and planning academic status, professional associations (16 indicators)	Strong
Primary Care Process		
Access	Density of workforce, geographic availability, access to practice level, affordability of services, patient satisfaction (12 indicators)	Weak
Comprehensiveness	First contact care, disease management, sole GP contacts, medical procedures, prevention care, health promotion, medical equipment (10 indicators)	Medium
Continuity	Longitudinal continuity, informational continuity, relational continuity (9 indicators)	Strong
Coordination	Gatekeeping system, skill mix, collaboration of care, public health integration (7 indicators)	Weak
Overall primary care strength	Scores for the structure dimensions are positively associated with each other (i.e they influence each other's score), while those for the process dimensions are not.	Weak

Source: compiled by L&RS from Kringos *et al* (2013a)

But they also suggest that there is a trend towards larger scale practices, allowing for a variety of advantages including extended range of services, focus on population health management, investement in IT and other services, and the development of tailored care for people with multi-morbidity.

In terms of registration, there are broadly two groups of countries – those which require patients to register with a GP and those that don't. It has been argued that registration is beneficial for continuity of care.[59]

GPs generally act as 'gatekeepers' to specialist health care. Self-referral is rare but does occur (Sweden).

What financial barriers exist to access primary care?

Financial barriers to access to primary care can result in unmet needs for health care, or greater pressure on secondary care. There are many different approaches to keeping financial barriers low to maximise access. For example, primary care can be entirely free or it can be free for selected groups (as in Ireland). Alternatively, where there is cost-sharing (e.g. some form of fee is payable) the level of this can be kept low, or there can be exemptions from cost-sharing for particular individuals, or there can be caps on the level of cost-sharing.[60]

A 2009 OECD survey[61] asked 29 countries to indicate the 'typical' range of costs covered for GP contact. Of these 29:

- 12 countries covered 100% of the cost of GP contact;
- Another 13 covered over 76% of the costs;
- Of the 29 countries surveyed only Ireland reported no coverage for any costs. However, this applied only to those who had no medical card or GP visit coverage.

In the PHAMEU study of 31 countries Kringos *et al* (2013) found that almost half the countries had financial obstacles to seeing a GP in that patients had to pay for part of the costs of a visit. They found that Ireland had the biggest level of [formal] co-payments for those without a medical

[60] Thomson, S. and Mossialos, E. (2010) 'Primary Care and Prescription Drugs: Coverage, Cost-sharing and Financial Protection in Six European Countires' *Issues in International Health Policy* Vol.82, March.

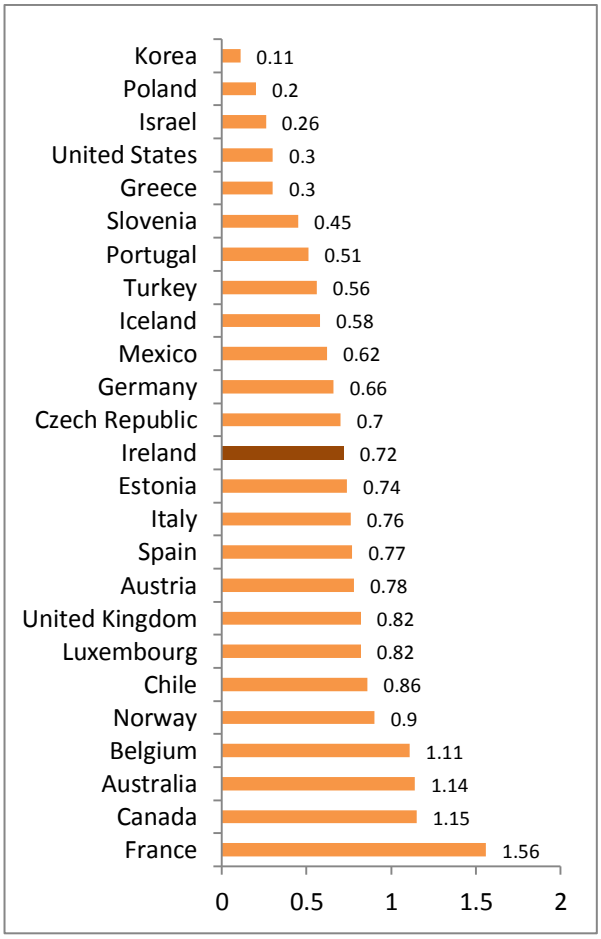
[61] Paris, V., Devaux, M., and Wei, L. (2010) 'Health Systems Institutional Characteristics: a survey of 29 OECD countries' *OECD Health Working Papers No. 50*

card. They cited Irish costs as about €60 to €80 per visit with no reimbursement. This figure (which was based on 2009 data) seems likely to be an overstatement of current GP visiting costs – see discussion above.[62]

How many GPs?

Accessability of primary care can be affected by various factors, including GP shortages or financial barriers. GP numbers are addressed here and financial barriers below. One potential outcome of GP shortages is greater reliance on hospital outpatient care which may not be optimum for patients or the wider health service.[63] Comparative data on the number of GPs are collected by the OECD and the latest data is for 2011 (see Figure 1).

Figure 1: GPs per 1,000 population, OECD 2011



Source: OECD *Health Database 2013*

There is substantial variation across the OECD from a low of 0.1 per 1,000 to 1.5 per 1,000. Ireland is in the middle of the distribution with 0.7 per 1,000 (see Figure 1).

There are comparability problems, however. Figures for some countries exclude trainees, while others (including Ireland) include trainees. Irish data is based on the number of GPs registered with the Irish College of General Practioners, and may include GPs not currently practising.[64] Methodological changes since 2011 also means that Irish data prior to this is not comparable. Additionally, the data are for national level, and there may be variation geographically within countries (as we have seen with respect to Ireland).

How well are GPs paid?

OECD data indicates that Irish GP incomes are towards the top end of GP incomes in the OECD. The data also show a decline in GP income between 2009 to 2011, but do not capture any changes to GP income from 2011 (which is the most recent data available).

Figure 2 (over) illustrates GP remuneration as a ratio to the average wage. It should be noted that for highly skilled professionals, incomes in excess of the average wage would be expected.[65] In 2011, self-employed GPs in the UK earned 3.4 times the average wage, followed at 3 times the average wage by GPs in Canada, the Netherlands and Ireland. The Irish ratio is above that for self- employed GPs in France (2.1) Denmark (2.7) Belgium (2.3) Austria (2.7) and Australia (1.7)

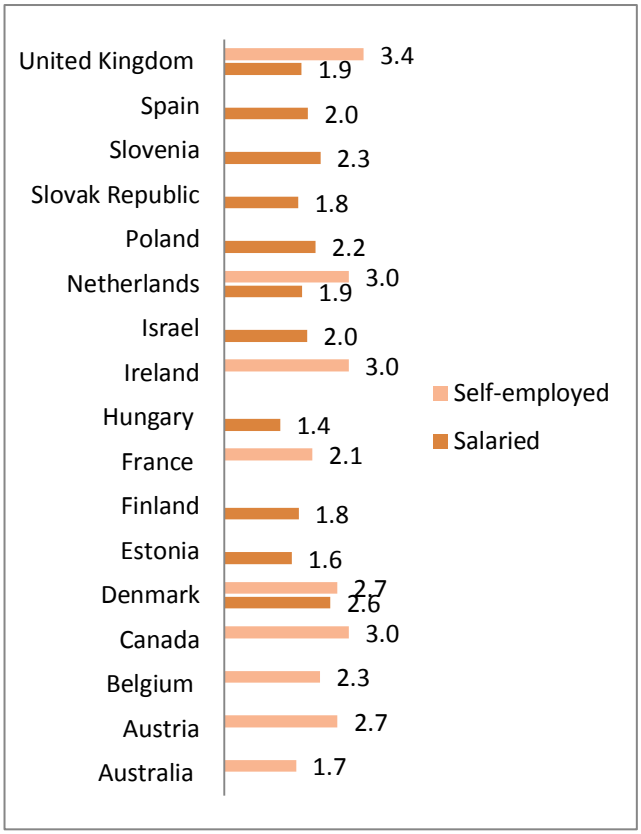
The European Observatory Report (2012) suggested that there was 'considerable scope' for a reduction in Irish GP income, based on data for 2009 when the ratio was 3.5 times the average wage. However, they also noted the need for improved data. Subsequently, there have been improvements in the comparability of remuneration data.

Previously, only GMS income was included, and practice expenses were excluded. However, from 2009, self-assessed income tax data as reported to the Revenue Commissioners is

[62] The figure was taken from European Observatory, *Health Systems in Transition*, Vol 11, no 4 2009 Ireland, Health System Review (L&RS correspondence with researcher).
[63] Masseria *et al.* (2009) p. 12.
[64] Figures exclude physicians overseas and those over 70 years old.
[65] OECD. *Health at a Glance 2013*

used, so that both income from private patients and practice expenses are included. Continuing efforts are being made to improve comparability, with the potential to affect future rankings.[66]

Figure 2: GP remuneration, ratio to average wage, 2011 (or nearest year) selected OECD countries.



Source: OECD, *Health Database 2013.* See note below for individual country qualifications.[67]

What are the main methods of paying GPs?
The three key methods for remunerating GPs are fee-for-service, capitation or salary, and there is also a fourth mixed method combining varius elements (see Table 4 over). Each has strengths and weaknesses, particularly in terms of the incentives to providers to act in particular ways. As noted, remuneration methods can also affect access. A selection of arguments for and against different methods are summarised in table 4.

Key arguments[68] are that where patients are essentially a cost to the provider (e.g. where GPs receive a salary or a capitation payment) then there are incentives to reduce costs. This may be by using less costly staff to provide care, by health promotion strategies to reduce visits, or referring elsewhere. It has been also suggested that this may incentivise providers to reduce the time spent with patients or to avoid patients who may consume more time. Conversely, where fee-for-service means patients are essentially a resource, providers may be incentivised to over-provide care, or there may be few incentives to maximise health promotion. However, this method has been said to promote better access to care for patients. There are also administrative costs and benefits to each system.

The arguments for each should not be over-stated – the evidence is complex, and control measures (e.g. audits, payment caps, bonuses - depending on payment method) and other methods can target known problems.

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It has been suggested that trade-offs between the three traditional methods are leading to increased use of some form of mixed method, frequently with an element of pay for performance.[69] These methods vary substantially but might target things like record-keeping, achieving quality targets of various kinds, patient satisfaction aand so on.

Pay for performance is also not unproblematic. For example, it has been suggested there can be problems with measuring outcomes (for example, if they depend on patient behaviour),[70] and also that good quality evaluation is limited.[71]

[66] L&RS communication with Department of Health. For example, locums are currently not included, and it is hoped that the coverage of the data may also improve.

[67] Data may underestimate if it includes physicians in training (Australia), or overestimate if it includes practice expenses (Belgium) is net income (France), is for public sector workers only (Hungary) or includes specialists in training (UK).

[68] Hindle and Kalanj. (2004); Kringos *et al* (2013a); Brick *et al* (2010)

[69] Brick et al. (2010) op.cit.; Roland and Nolte (2014) 'The Future shape of primary care' *British Journal of General Practice* Vol.64, no.619, 63-64

[70] Brick *et al*. (2010), op.cit.

[71] Roland and Nolte. (2014) op.cit.; Masseria *et al.*(2009) op.cit.

Table 4: Overview of GP remuneration

Form of payment	Arguments for	Arguments against
Salary Fixed amount of money for given time period	Cost containment; Health prevention; Steady income for providers.	Possible incentives to cream skimming, reduce patient time and access, refer elsewhere.
Capitation Fixed fee for each patient on books, often weighted for characteristics which affect demand for health care such as sex or age.	Patients a cost to provider – cost containment (see above); Promotes patient registration;	Possible incentives to reduce patient time, refer elsewhere. Poor weighting can lead to cream skimming or low provision in disadvantaged areas
Fee-for-service Payment for each item of service e.g. consultation.	Increases productivity; Incentives to see more patients – better access to care;	Patients a resource to provider - possible incentives to over-provision; Administrative costs can be higher if State main payer; No incentives to health prevention, or use of less costly provision.
Mixed Capitation or salary plus often a pay for performance element of some kind	Reward performance consistent with health policy objectives;	Difficulty in measuring performance; Neglect of unmeasured areas; Prioritise management of single conditions over integrated care;

Source: compiled by L&RS from Hindle and Kalanj (2004); Brick *et al* (2010); Kringos *et al* (2013) inter alia.[72]

Issues and debates

A new contract

The Programme for Government states that a new GP contract would provide incentives to GPs to care more intensively for patients with chronic illnesses, resulting in less pressure on the hospital system.

The current GMS contract is set out in a series of letters and circulars issued by the Department of Health. The contract is between the HSE and the individual GP, but the contract has formerly been subject to agreement between the HSE and the Irish Medical Organisation (IMO) or their predecessor organisations.

As noted above, in January 2014 consultation on a new draft contract commenced. The government has argued that as GPs are self employed professionals it cannot, under competition law, negotiate on fees with the IMO. The IMO rejects this position. A case before the courts between the IMO and the Competition Authority (due to be heard in April) may resolve the issue.[73]

The launch of the consultation on a draft GP contract for under-six provision was greeted critically by a range of GP bodies. For example, the IMO suggested that the Government was using the extension of GP cards to children under six as a 'trojan horse' to push through a

[72] Hindle, D. and Kalanj, K. (2004) 'New General Practitioner Payment Formula in Croatia: Is it consistent with Worldwide Trends?' *Clinical Services* 45 (5) 604-610; Brick, A., Nolan, A, O'Reilly, J., and Smith, S. (2010) Resource Allocation, Financing and Sustainability in Health Care: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector Dublin: ESRI; Kringos et al. (2013) op.cit.

[73] Competition Authority -v- Irish Medical Organisation.

radical reform of the terms and conditions of doctors without any negotiation.[74] The National Association of General Practitioners stated that after consultation with members they 'reached the conclusion that the draft contract … on offer is so morally, economically and practically flawed in content that it merits no further consideration.'[75]

The contract is likely to change following the consultation process[76] and is not examined in detail here, although some provisions are discussed further below where relevant.

Some key issues identified by GP bodies, in no particular order, include:

- Increasing number and complexity of consultations;
- Issues around clinical independence;
- A need for additional resources and expenditure;
- Standards for premises;
- Impact on patient care;
- Bureaucratic and adminstrative requirements;
- Issues around working with PCTs.

GP workforce: supply issues

Various studies over a number of years have suggested potential shortfalls resulting from a combination of GP training and supply factors, feminisation of the workforce (a factor because of the greater propensity of women to work part-time, and to retire earlier), an ageing GP workforce, population growth and population ageing (increasing demand), and other factors including policy changes relating to a greater priority on primary care.[77] For example, a 2010 study of GP workforce planning[78] suggested that, without intervention, the supply of GPs would be 5.7% less than required in 2012.

Various studies and reports (including the 2006 *Report of the Postgraduate Medical Education and Training Group*[79]) argued for increases in GP training.[80] In July 2010, the GP trainee intake was increased from 120 to 157 training places.

In their analysis of GP workforce planning Teljeur *et al* (2010a) pointed out that, due to the lengthy training process for medicine, adjusting supply to meet demand in a timely manner poses difficulties.[81] Hence they suggested that increasing training places would enable supply to meet demand, but only after 2019. Further increasing the number of GP places would also require increases in funding for medical education. Alternative approaches outlined in their study included increasing GP productivity, promoting later retirement, recruiting GPs from abroad, and substituting nurse care for some elements of GP care. The latter however would involve recruiting large numbers of practice nurses, and allowing them to deliver a wider range of GP services.

The Programme for Government suggests that the number of practice nurses would be increased to allow GPs to delegate care when appropriate.

The geographical distribution of GPs raises different issues. One factor is that as GPs are self-employed practitioners, the choice of where to practice is up to them, and the HSE cannot control where practices are located.[82] Hence incentives might be used to adjust supply in particular locations (see discussion above), though the incentives may need to vary depending on whether it is addressing an urban or rural area. Such incentives have been used in other countries.[83]

Access and equity

Access issues have wide ranging implications, both for demand for services, and potentially for the wider health service. The arguments for reducing financial barriers to access are diverse. For example, the European Observatory Report noted that:

[74] https://www.imo.ie/news-media/press-releases/press-releases-2014/imo-gps-warn-that-the-gov/index.xml
[75] http://nagp.ie/news-media/press-release-new-gp-contract-morally-and-economically-flawed
[76] See Statement by Mr. Alex White T.D., Minister of State for Primary Care, 25 February 2014.
[77] Thomas and Layte. (2009) op.cit.
[78] Teljeur *et al*. (2010b) op.cit.
[79] The 'Buttimer Report'.
[80] Thomas and Layte. (2009), op.cit.,
[81] Teljeur *et al* (2010b)
[82] Burke, S. (2010) 'Chronic shortage of GPs in Ireland soon to become critical.' Blog post accessed 27/02/104)
[83] Teljeur *et al* (2010b), p.1081

> 'The nature of health coverage in Ireland produces a complex set of conflicting incentives for patients and providers, leading to outcomes that are often contrary to public health poicy objectives….Some of these incentives may result in inefficient patterns of use. For example, the presence of high user charges for GP visists may encourage [some] patients to go to acute public hospitals for the management of chronic disease, rather than having their conditions managed by a GP.. ..This is a highly unsatisfactory pattern of use because it disrupts continuity of care, leads to worse outcomes and often results in higher cost due to complications being recognised late.'

As noted, the comparative evidence points to greater subsidisation of GP contact as the norm in Europe - but is not necessarily prescriptive about the form this subsidisation should take. While primary care may be wholly free, it may also be subsidised to varying levels via different forms of cost-sharing. From an Irish perspective, a 2010 report on resource allocation in health proposed a system of graduated subsidies for primary care, with four categories, all of which would receive some level of subsidy, but with cost-sharing for some categories.[84]

A key debate about the extension of eligibility for free GP care is related to the impact on demand for GP services in the context of current resources. There is evidence that GP utilisation is more likely in the context of free GP care.[85]

The IMO has indicated that it is supportive in principle of GP care that is free at the point of access.[86] However, it has stated concerns with regard to current resources. In its submission on the draft contract it argues that there will be a need for up to 11 extra consultations just from the proposed under six measure, which it states will require a need for extra doctors, nurses, receptionist staff, premises, computers and HSE adminstrators. Some 180,000 children currently have access to a GP service without fees; the proposed measure would add another 240,000.[87]

Challenges of establishing primary care teams

Proposals for UPC are predicated on a number of features, including registration with a PCT. However, the implementation of the Primary Care Strategy over the past decade has been described as 'very challenging':

> 'There has been a lot of success but there have also been a lot of questions around how well the teams are functioning and there are a lot of challenges to do with GP participation in the team.'[88]

The Strategy provides for between 400-600 PCTs by 2011 - the most recent HSE data states that there were 426 teams at the end of 2012. However, there has been substantial debate about HSE criteria for what constitutes a fully functioning PCT.[89] In May 2012, the ICGP chief executive suggested that only a third of PCTs were working effectively, a third were partly functioning, and another third existed in name only.[90]

In a report outlining GP perspectives on PCTs, the ICGP endorsed the 'theoretical basis for PCTs', but also outlined a very wide range of barriers to GP involvement under a number of different headings: management; meeting structure; disintegration of services;

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[84] *Report of the Expert Group on Resource Allcoation and Financing in the Health Sector*. (2010) Dublin: Department of Health and Children

[85] Nolan, A., Smith, S., (2012) The effect of differential eligibility for free GP services on GP utilisation in Ireland, *Social Science & Medicine* (2012); McNamara, A. Normand, C., nd Whelan, B. (2013) *Patterns and determinants of health care utilisation in Ireland* Dublin: TILDA;

[86] IMO (2011) *Submission to the Department of Heath Strategy Statement in 2011-2014*

[87] Department of Health and Children FAQs on provision of General Practioner services without fees to children aged five and under

[88] University of Limerick Professor of Primary Healthcare Research, Anne MacFarlane, cited in 'Study to examine primary care reform', *Irish Medical Times*, 26 February 2014.

[89] See for example Irish College of General Practioners (2011) *Primary Care Teams: A GP perspective*; and Comptroller and Auditor General (2010) op.cit.

[90] Cited in Houston, M. (2012) 'Little progress on primary care teams says College CEO' *Irish Medical Times*, 16 May 2012.

confidentiality; access and eligibility; information technology and communication; and infrastructure.

The European Observatory team also identified barriers to progress, including IT constraints; the absence of a health and social care network; poorly functioning change management processes; difficulties with the re-assignment of staff; and difficulties in sourcing accommodation for PCTs.

The HSE *National Service Plan 2013* provided for additional funding of €20 million to support the recruitment of primary care team posts and enhance the capacity of the primary care sector. Additionally, Government intention to develop as many primary care centres as possible via direct build by the HSE, leasing arrangements with the private sector, or public private partnerships has been stated.[91]

Towards a wider range of service provision

One of the major rationales for primary care reform is to reduce pressure on the hospital system by better management of chronic conditions. Additionally, promoting health and wellbeing is one of the core principles underlying the health reform programme. The Department of Health described the draft contract as being more comprehensive than the existing contract, and including greater specification of services to be provided:

> 'Proposed scope of service is not limited to 'diagnosis and treatment' but includes participation in active health promotion, disease surveillance, prevention and appropriate management of chronic conditions.'

The two areas of chronic care and health promotion raise separate issues, but a common factor is the potential for additional workload for GPs. Hence the IMO noted that the proposed expansion and reorientation 'will have an enormous impact on both clinical and administrative workload of GPs'.[92]

Proposals in the contract for 'wellness checks' for children were critiqued both in terms of additional workload, and in terms of whether there is sufficient evidence base to support them as a public health measure. The IMO submission questioned what they saw as the transfer of these services from community health doctors and public health services without a rationale, with a potential for 'tick box' consultations to take priority over acute consultations.[93]

As described above, the comparative literature suggests that payment methods may offer incentives or disincentives to offer preventative care.

Paying GPs

As outlined above, proposals for UPC suggest payment primarily by capitation. One key implication would be that the portion of GP income currently from private practice (which is on a fee-for-service basis) would be paid via capitation, beginning initially with the under-sixes.

As outlined in some detail, there is substantial variation cross-nationally in how GPs are paid. The 2012 European Observatory Report suggested three main ways of improving GP payment in Ireland:

- Increasing the proportion of GP income from capitation to enhance efficiency and access – currently around 52% of GP payments from the GMS is from capitation;
- Using more sophisticated risk adjusters than the current age, gender and distance from surgery;
- Introducing some element of pay-for-perfomance, perhaps on a short-term basis, and with careful attention to design issues, (given the potential problems discussed above).

The IMO has previously stated that:

> 'Capitation is an overly simplistic method of deciding on payment. Patient attendance must be included in remuneration calculations as well as the patient demographic that a GP provides

[91] Reply of the Minister of State at the Department of Health, Alex White T.D., to PQ Ref. no. 3491/14 28/01/2014

[92] IMO submission on draft under six contract, February 21 2014.

[93] ibid.

> care for. To disadvantage Doctors working in deprived areas further would be unacceptable to the IMO'[94]

The level of fees to apply for providing the new services are not included in the draft contract proposals. The IMO has written to the Minister to state that 'a negotiation which addresses the scope and content of the [proposed under six] contract without addressing what GPs are to be paid for delivering the services is impossible and meaningless.'[95]

Conclusion

Reform of primary care has been on the agenda for over a decade, reflecting a perception that the current system is fragmented, poorly developed, and inequitable, and that a reformed system would contribute to wider health goals. Few seem to dissent that there is a need for reform, and the international evidence clearly indicates that Ireland is an outlier in terms of coverage for primary care, providing essentially no subsidisation of GP visits for some 57% of the population.[96]

However there are many challenges to moving towards the types of structures and processes that exist in countries with strong primary care. In particular, while there are clear advantages to offering 'free' access to primary care, there are also potential issues relating to resources, including with regard to GP numbers and utilisation rates.

Recent international evidence endorsed the widely held view that stronger primary care structures lead to better population health outcomes and other health goals. However, it also suggested that overall health expenditures were *higher* in countries with stronger primary care structures, perhaps because maintaining strong primary care structures is costly. More research is required to assess why this might be the case, but it indicates that stronger, more effective and more equitable primary care may have important cost implications, at least in the short term.[97]

It is clear that the issue of resources is an important faultline for conflict between GPs and the Department of Health, with the IMO disputing that the €37 million earmarked for the proposed under-six proposals will adequately meet the costs of the scheme. In their 2012 analysis of financial pressures on the health system at that point, the European Observatory team stated that:

> 'Efficiency gains from planned and additional reforms will not be sufficient to fund the Government's commitment to establish universal access to primary care and strengthen service delivery.'[98]

As discussed above, the Report pointed to some potential scope for addressing GP remuneration (subject to some qualifications about data), in addition to a range of other policy options (not discussed here). However, GP remuneration is a complex area:

> **'**The challenge for payers, regulators and governments is how to create a set of incentives that support innovation, experimentation and evolution, that hold providers firmly to account but without unintended adverse consequences, bureaucracy and box ticking.'[99]

An international study of GP remuneration concluded that GPs tend to favour the model they are most familiar with – 'in countries with fee-for-service private practice, general practitioners have tended to oppose capitation and to reject salaried practice with vigor.' [100]

GPs and their representative bodies have made it clear that they are looking for substantial negotiation around both their role and their remuneration, and this seems likely to be a fundamental challenge to UPC as currently constituted.

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[94] IMO (2011) op.cit.
[95] IMO Press Release 10/03/2014: IMO warns that Governments plans for so called free GP care are doomed to failure
[96] There is some small subsidy e.g. caps on pharmaceutical costs.
[97] Kringos *et al* (2013) op.cit.
[98] Thomson, *et al.* (2012) op.cit.
[99] Edwards *et al.* (2013) op.cit.
[100] Hindle and Kalanj. (2004) op.cit.