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A Future Together

Building a Better GP and Primary Care Service

DECLARATION OF INTERESTS

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He has a General Medical Services contract from the HSE and is in receipt of fees and allowances for patients on his list.

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She declares no conflict of interest.

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Executive Summary

Reform of primary care in Ireland has been on the agenda for several years. The current system is seen as fragmented, poorly developed and unfair. To achieve reform requires a decisive shift towards general practice. For such a shift to occur the State needs changes in its contractual arrangements with General Practitioners (GPs). Such changes will then facilitate wider changes in primary and community care services.

Scope of this report

- An international review of how primary care operates internationally was conducted with a focus on the place of general practice.
- Consumer research, using both quantitative and qualitative research methods, was undertaken to give a good understanding of the patient experience of GP services and patient priorities.
- Targeted, qualitative interviews were also conducted to get the views and insights of key individuals working in the wider healthcare system.

Spending

The overall public and private spend on general practice in Ireland in 2014 was €858.6 million. Forty two per cent of the population has various levels of General Medical Services (GMS) coverage. This resulted in €543 million or 63% of the entire spend on general practice. GMS patients consult on average 5.63 times per year and private patients 2.69 times per year. We have estimated that 4.5% of the entire health budget is spent on payments to General Practitioners (GPs). This is the lowest proportion of the comparable countries that we studied.

Staffing

Ireland has 6.26 general practitioners per 10,000 population. This is broadly similar to Denmark, Germany and the Netherlands but significantly lower than Scotland. Countries that are rated highly on measures like access and services, have higher numbers of practice based staff including allied health professionals. Ireland has the lowest practice based staff ratio of the countries we studied.

Long term illness

Most countries are struggling with chronic disease management with care being GP or nurse led. Single chronic diseases are easier to manage but most patients over 60 years of age have two or more chronic illnesses.

A variety of guidelines are in place but they can result in over treatment and increased referral rates. GPs fear criticism or sanction for sub-standard care if they do not adhere to guidelines. There is good evidence that seeing the same doctor regularly results in significantly fewer admissions for patients with long-term conditions. Looking after complex patients with multiple illnesses in general practice requires additional time. Reducing hospital admissions is an important outcome for patients and the overcrowded hospital system.

Patient satisfaction

Overall 90% of patients in the consumer studies were satisfied with their last GP visit. Most patients said they found it easy to find a GP. Patients were prepared to go on a waiting list for a recommended GP. Ease of access for appointments was also rated highly, with most parents of children commenting on being given priority and same day appointments. The cost of seeing the GP deterred 1 in 3 patients. This was highest among those paying for the service and younger patients.

GP out-of-hours service

These now provide over a million consultations annually. The consumer surveys indicated high awareness and use of this service. Accessibility and satisfaction with out-of-hours service was highly rated.

Information technology

General practices in Ireland are early adopters of Information Technology (IT). It is used for recording administrative, clinical and prescribing details, and for screening programmes. Electronic referrals (e-referrals) to hospitals are increasing but links with hospital IT systems are a cause of concern for general practitioners.

Diagnostics

Access to diagnostics, in particular radiology, is an ongoing bugbear for GPs. Worryingly, poor access to diagnostics was cited as a factor by GPs in training, for leaving general practice.

Future GPs

GPs in training were not interested in singlehanded practice. They see themselves working in a multi-disciplinary team in order to provide better patient care. A significant minority is unwilling to take on a GMS contract on graduation from training due to the risk of becoming an employer and the complexity of the contract. Many are interested in becoming salaried GPs for a limited amount of time before they become partners in a practice. They are willing to become managing partners later on in their careers.

Nurses

Nurses were rated highly in the consumer surveys and considered to be central to delivering high quality care and ensuring continuity of care. Practice nurses want to see more incentivisation for chronic illness care in the practices. They asked for upskilling in chronic disease, mental health, wound care and health maintenance and prevention.

Pharmacists

Pharmacists saw themselves as being able to share some aspects of chronic disease management with GPs. Community pharmacists play an important role in medicines safety and preventing drug interactions.

Clinical pharmacy is being developed in the National Health Service for medication management in chronic disease. Such a pharmacist is employed by the practice and does not have a role in the provision of medication. Having a clinical pharmacist in a general practice means the GPs can focus on the management of patients with complex conditions.

Transitional funding

Providing long-term illness care, improved diagnostic services, increased practice based staff and modern IT requires additional funding. Primary care and general practice, as now structured, will be unable to cope with additional workload. Transitional funding spread over a number of years is needed to allow general practice and primary care in Ireland to be strengthened to international standards. Some is one off and the remainder is recurrent. There will be some quick wins in providing services close to where the patient lives. Longer-term gains in equity and wider healthcare goals are an ongoing process and will take much longer.

Allied health professionals

While the impetus for this report came from the new GP Contract negotiations there is an increasing interest among allied health professionals (AHPs) in playing a part in caring for patients in primary care. There is a future together for AHPs and GPs in developing primary care as has been shown internationally. It will require the various professional elements to get to know each other's way of working, skillsets and willingness to work as a team. As it stands there are significant contractual and employment issues to be ironed out.

Part 1

Background and Context

1.1 Background

To achieve the objectives of the health reform programme, the Health Services Executive sees that fundamental changes are required in their contractual arrangements with GPs. Such changes will facilitate the vision for primary care and community care services.

The authors of this report were commissioned by the HSE to examine the international evidence for change and to summarise the findings of the studies conducted by Coyne Research, on behalf of the HSE, and integrate them into this report.

1.2 Main Objective

The main objective of this report is to conduct an international review of the place of GP Services in the Irish healthcare system, which, at a policy level, is committed to achieving a decisive shift in focus and resources towards a stronger and more integrated primary care, including the following:

- Commitment in Government policy to introducing universal healthcare – GP care free at the point of access[1];
- Move from emphasis on acute care towards preventative, planned and well-coordinated care, health surveillance and disease prevention; and
- Involvement in Primary Care Teams and Social Care Networks to provide the foundation for a new model of integrated care. Government Policy is for the population of the Republic of Ireland to have access to GP care free at the point of access, on a phased basis. A new GP contractual framework will provide a unique opportunity to reorient the focus of primary care. This will be toward active health promotion, disease surveillance, prevention and appropriate management of chronic conditions in addition to diagnosis and treatment.

This report will inform the development and planning of the new GP contract. It will help the thinking required to provide a more patient-centred primary care service for the healthcare system and patients. It will summarise feedback from relevant key stakeholders to support the development and negotiation of a new modern GP service for the future in Ireland. It will present a summary of the findings of the stakeholder engagement and research process. The full stakeholder report will be made available for public access along with this current report.

1.3 Scope of the Work

1.3.1 National and international evidence review and comparison

This research will review how primary care systems operate in jurisdictions outside of Ireland with a particular focus on general practice systems. It will explore how other jurisdictions position GPs within their primary care systems. The research will seek out opportunities that have been successful for primary care services abroad to collaborate with other sectors/services/divisions to include: administration; nursing; pharmacy; delivery services; logistics; Information and Communications Technology (ICT); and other general supports.

- **Consumer research** – this was undertaken by both quantitative and qualitative research methods amongst the wider public to build a robust understanding of patient experience of GP services and their priorities. It included GPs in practice and GPs in training.
- **Targeted qualitative interviews** – these were carried out to ensure that the input from key individuals with specific insight to the wider healthcare system, were taken into account.
- **Plenary session** – this was convened by the HSE to solicit the views of the wider health service community. The purpose was to inform interested and committed people about the scope, nature, results and provisional conclusions of the research to date and to elicit their opinions for inclusion in the final report.

1.3.2 International evidence

There is no shortage of international evidence showing that primary care that works well, improves health outcomes and lowers costs[2]. Healthcare policy is now focused on primary care, which has been the most poorly developed link in the system[3]. Any investment in primary care will provide returns in the longer term[4].

Recent evidence from Vermont indicates that every $1 dollar spent on GP oriented primary care returned over $5.8 dollars in healthcare savings[5]. The authors attribute these savings to the reorientation of their healthcare system towards primary care, underpinned by legislation.

Internationally primary care is playing a bigger role in the coordination of healthcare between GPs and hospitals[6]. This is now possible with electronic medical records and other electronic methods of enabling better communication within primary care, and between primary care and other parts of the healthcare system and the wider public sector. In Ireland these benefits are already achieved in areas such as e-referral for symptomatic cancer services.

1.3.3 Ever increasing demand for healthcare

All healthcare systems in the Western world are struggling with growing demands for healthcare and are trying to find the best way forward both in terms of cost and service provision. The authors of this report initially wanted to find examples of success and illustrate them for consideration in Ireland. It proved to be not that simple. Countries and regions are joining the primary care journey at different points with wide variation in service development as a result. Finding comparable data is difficult and attempts at standardisation have only been made recently in Europe.

Healthcare demand is increasing in the Western world:

- Increasing survival to old age means that there are more people with chronic illnesses requiring proven treatments;
- There are increased expectations among patients for more extensive and, indeed, universal healthcare; and
- Advances in technology mean that sophisticated and effective interventions can often prolong good quality life.

The increasing costs of modern healthcare are forcing governments and insurers to look for more cost effective ways of delivering healthcare. Hospital admissions are often more expensive than treating patients at home or in their community. Patients want to be looked after in their community.

1.4 Definitions

Some definitions are clarified below, as there is confusion due to overlapping terms:

- Primary care
- GP care
- Community care

1.4.1 What is primary care?

Primary care fundamentally means an open door through which patients come at their own discretion and without a gatekeeper. It is therefore demand led and subject to individual, family and community influences.

The 2001 Primary Care Strategy *"Primary Care: A New Direction: Quality and Fairness — a Health System for You"* defined primary care as being *"an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease, to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social wellbeing"* [7]

Most people see primary care as that which is carried on outside a hospital. It is also confused with community care and with general practice.

There are many definitions of primary care but the most widely accepted is that it involves:

1. Health promotion
2. Prevention
3. First contact advice for patients
4. Diagnosis
5. Care of common diseases
6. Coordination of care in the community and hospitals
7. Referral usually to hospitals or clinics

Much primary care is not dependent on GPs and is being carried out by health promotion officers, public health specialists and nurses – sometimes without direct contact with patients. General practice is an important part of primary care of course, but it is currently more focused on the illnesses suffered by patients than on prevention.

1.4.2 What is GP care?

There is an inevitable overlap between primary care and GP care.

GP care is now seen as:

- The patient's first contact with the health services for illness. The patient's story usually needs clarification before any action is decided.
- It is person rather than disease focused. For example GPs refer to Mrs. Smith who has osteoarthritis rather than as a case of osteoarthritis.
- Comprehensive care from cradle to grave. A GP starting out in practice may provide antenatal care for a patient and many years later provide terminal care for the same patient.
- Coordination of care between the many agencies involved especially for the care of complex chronic illnesses. This is in many ways the most difficult area for general practice. It can involve several hospital departments, social services and the patient's family, who suffer needless distress because of poor communication between the various services involved.

1.4.3 What is community care?

It is a collection of services that can include public health and community nursing, home help, physiotherapy, occupational therapy, chiropody, day care and respite care. It has various levels of eligibility for patients but is generally available to all means-tested medical card holders. It is linked to a geographical area rather than to an individual general practice. GPs in Ireland rely on community care services to provide relevant and appropriate care to their GMS patients[8].

1.4.4 What is GP led Primary Care?

'GP led primary care' makes sense to GPs and is supported by the National Patient Forum (see later). It is a term that has evolved from the GP representative bodies in Ireland and Northern Ireland [9-11]. There is consensus on the concept among GPs and the implications are discussed elsewhere in this document. There are some examples on the ground of GP led primary care working well, but little published evidence available. Patients see their GP as central in their interaction with the wider primary and secondary care systems.

GP led primary care as envisioned by GPs is a better resourced version of what is already going on in general practice.

There are three broad levels at which GP led primary care could happen:

a) the GP attends or in some cases leads weekly or monthly meetings of a multidisciplinary team in the practice or at a venue close by. This occurs in some practices now but GPs regularly claim that they do not have the time for the team meetings.

b) the multidisciplinary team reports to the GP on the condition of his/her patients and has access to the patient files. Team members are employed by other agencies such as the HSE but the reporting line is via the GP. Staff could be seconded to general practice from other agencies, as GPs in small businesses are fearful of the risks of having employees. In Ireland general practice staff are often on hourly rates and entitled only to statutory benefits. HSE staff, doing similar work, are likely to be salaried with additional benefits.

c) the multidisciplinary team budget is devolved to the GP who manages it and who employs the team members relevant to the practice. In the Pinnacle network in New Zealand, whose CEO we interviewed for this report, human resource and back office facilities that include staffing and supplies are provided for practices. In Ireland because of the small size of most practices it would be necessary for groups of like-minded practices to develop an entity to employ staff and deploy them as needed. Local GP Co-operatives (Co-ops) now have governance and managerial experience that could be deployed in extended budgetary and staffing roles.

There is thus a spectrum of GP led primary care ranging from the attendance at meetings to devolution of the primary care budget and consequent employment of staff. Whichever level of GP led primary care evolves, upskilling of key staff and significant cooperation of all the players involved is needed. Allied Health Professionals (AHPs) have provided a view of enhanced primary care that sees upskilled GPs, Nurses and AHPs working together[12].

1.5 How Has General Practice In Ireland Changed?

A recent report of the Structure of General Practice in Ireland[8] found the following:

- GP numbers increased by 20% from 2005 to 2015.
- The general practitioner population is aging, with 14% of practising GPs now over the age of 65.
- Women now constitute 42% of the GP workforce, are a younger demographic and more recently qualified. Women and men do not want to work in the same pattern as their older colleagues. This has workforce implications for the country.
- 93% of GPs are now in out-of-hours Co-operatives and see nearly one million patients outside their normal surgery hours.
- Access to hospital-based diagnostics has declined; for example the report found access to ultrasound has declined by 56% for GPs since 2005.
- Most GPs now practice from good well equipped premises, with about 10% practicing from a primary care centre.
- The biggest change in recent years has been a decline in the number of singlehanded GPs who now comprise only 18% of the GP workforce.
- GPs are supported by nursing, clerical and management personnel in practices which are now well equipped with simple clinical and diagnostic equipment and computers.
- The local GP practice is now the place to go for services such as vaccinations and phlebotomy.
- There has been little increase in the systematic care of chronic illness.

1.6 How Is General Practice In Ireland Viewed Internationally?

The GP system in Ireland is long standing and strong on personal care with many families being looked after by the same doctor for two and sometimes three generations. Our GPs are reported as clinically well trained but with limitations on what they can do, aggravated by weak governance and poor investment[4].

Government direction for primary care is seen as in need of improvement[4, 8]. The reliance of the system on fees, which are paid by up to 60% of the population, is reported as extensive and restricts access to the doctor[4]. Access to community care is limited in that it is mostly restricted to patients with the full general medical services (GMS) medical card.

The primary care system in Ireland is at the very early stages of coordination, but has become central to healthcare at hospital and general practice. Coordinated care means better use of information technology where GP systems 'talk' to the others in the primary care team and also to local hospitals where patients are referred.

1.7 How We Measured Primary Medical Care Internationally

The authors of this report studied a broad range of systems from countries that are adopting a primary care approach to healthcare. The motivation of these countries is to control costs and provide better services. There is no shortage of such countries.

This document reports on primary healthcare in several different countries in Europe, in Vermont in the United States, and in Australia and New Zealand, all in varying stages of development.

We have chosen a wide number of specific measurements that will be summarised. Measurements will include how general practice is funded, organised and developed internationally. It will allow us to place Ireland at a point in the journey and provide guidance on where it should go to provide the best results for the investment made.

This report will include interviews with primary care specialists in Scotland, New Zealand and Vermont who are taking different approaches to the provision of GP led primary care.

1.8 Feedback From Patients And Those Who Work With GPs

Most feedback surveys about GPs are confined to patient satisfaction levels. This report broadens the net by including the views not only of patients but also other key personnel for whom having good general practice allows them to do a better job:

- patients and their advocates
- stakeholders such as hospital medical and nursing specialists
- practice nurses
- a private health insurer
- pharmacists
- GPs in training
- recently qualified GPs

The current GP contract

This contract is long established and was ahead of its time in establishing choice for patients through the 'choice of doctor scheme'[13]. The contract is now generally seen as outdated and is limiting the entrepreneurial and 'can do' nature of general practice. Concepts now established in other systems, such as multidisciplinary teams and the use of IT in establishing disease registers with alerts and recalls, are not catered for in the current contract.

The report is set in the context of a growing consensus among policy-makers, practitioners, commentators and the representative bodies that a decisive shift to GP led primary care is the key to transformation of the system[11].

Part 2

International Evidence Review

2.1 International Tables And Commentary On Comparisons

This section includes tables and/or comments comparing the international data from the countries/areas of interest over the following domains:

2.1.1 Spending on primary medical care internationally

2.1.2 IT practices and uses, data

2.1.3 Workforce

2.1.4 General practice training

2.1.5 Chronic disease management

2.1.6 Out-of-hours services

2.1.7 Scope and accessibility of general practice

2.1.1 Spending on primary medical care internationally

Table 1 Proportion of health budgets spent on general medical practice and per capita spending

			2014 OECD HEALTHCARE BUDGET ON MEDICAL PRACTICE[a]					
Population[b] Million		% 65 +	% of Health budget on General Medical Practices[c]			Health budget on General Medical Practices Per capita constant price PPPs (OECD) in US Dollars[d]		
			Public	Private	Total	Public	Private	Total
Denmark	5.6	16.5	4.4	0.3	4.7	193.0	13.2	206.2
Germany	82	21.2	14.0	0.8	14.8	656.5	36.3	692.8
Netherlands	16.8	16	7.5	0.0	7.5	366.1	2.0	368.2
Ireland	4.59	13.4[e]	2.6	1.9	4.5	121.9	90.8	212.7
Scotland[f]	5.3[g]	18	6.5	-	6.5	242.2[h]	-	242.2

[a] The figure for 'Medical Practices' is taken from the OECD. It must be noted, however, that this figure includes a small number of medical practices that are not specifically 'General Medical Practices'.

[b] Source: all data OECD http://stats.oecd.org/Index.aspx 2014 (unless otherwise stated)

[c] The figures in this column are derived from OECD http://stats.oecd.org/Index.aspx. Employing following selection: current expenditure on health (all functions) – Financial scheme all (gives total) 'Government schemes and compulsory contributory healthcare financing schemes' (gives public) – Private expenditure (gives private). Provider 'medical practices' (customized subset within Ambulatory Care). Using measure 'share of current expenditure on health'

[d] The figures in this column are derived from OECD http://stats.oecd.org/Index.aspx. Employing following selection: current expenditure on health (all functions) – Financial scheme all (gives total) 'Government schemes and compulsory contributory healthcare financing schemes' (gives public) – Private expenditure (gives private). Provider 'medical practices' (customized subset within Ambulatory Care). Using measure 'Per capita constant prices PPPs OECD expressed in dollars (2010). Again the figure for 'Medical Practices' is taken from OECD. It must be noted that this figure includes a small number of medical practices that are not specifically 'General Medical Practices'.

[e] http://www.cso.ie/en/releasesandpublications/ep/p-cp3oy/cp3/agr/

[f] Figures for the UK unless otherwise specified.

[g] Source: Scottish government www.gov.scot/Topics/People/Equality/Equalities/PopulationMigration

[h] Figure is for the UK. Per capita spending on health is higher in Scotland than in the rest of the United Kingdom (£2072 per year compared to £1926). Source: Steele D, Cylus J. United Kingdom (Scotland): health system review. Health Systems in Transition 2012; 14: 1-150

Limitations of data

Data are based on the OECD healthcare budget for medical practice, which is not that easy to define.

The OECD has five subcategories of providers of ambulatory healthcare: (1) medical practices, (2) other healthcare practitioners, (3) ambulatory healthcare centres, (4) dental practices and (5) providers of home healthcare services. Offices of general medical practitioners include establishments of doctors who hold a degree in medicine and are primarily engaged in the independent practice of general medicine. General practice in Ireland is a combination of medical practices, ambulatory healthcare centres and providers of home health care services thus fulfilling three out of the five OECD categories.

Source: OECD Health Data 2012. June 2012. http://www.oecd.org/health/healthdata.

It gets more complicated when international healthcare budgets are compared. The OECD methodology allows for a general comparison but a country specific analysis provides a more detailed view of spending. In Ireland the State pays for 42% of GP services. Thus the majority of patients (58%) have to pay to see the GP. From the 2015 Primary Care Reimbursement Services (PCRS) data the State spending on General Practice in Ireland suggests a per capita spend of $284.45 based on the eligible GMS population[14]. There are some additional State payments in support of GP training, GP out-of-hours Co-operatives and medical services provided by GPs to Nursing Units. This is a significant difference from the $122 (public) reported above. The reason for this disparity is that the overall OECD figure is derived from the total public and private spend. The private spending on general practice is comparatively low. For further discussion refer to the section below on public and private spending on healthcare in Ireland.

Comment:

The countries we studied have established primary medical care provided by GPs or family physicians. Data are available about their systems but lack the detail to explain the wide variations in spending. The OECD now uses spending per patient (expressed as purchasing power parity in US dollars) to compare national prices and to provide a better international picture. Based on health economics advice we have used this method in preference to proportion of gross national or domestic products as these figures can vary, as is the case in Ireland.

One of the big drivers of healthcare is the increase in the over 65 age group. The EU average for the 65-plus age group is 17%. In our table this age group ranges from 21.2% in Germany to 9.9% in Israel. Ireland's over 65s are at 13.3% which is at the lower end of the countries studied.

Table 1 shows the proportion of the overall health budget spent on general medical practices, which from their definition are mostly general or family practices. This 2014 figure ranges from 16.7% in Canada to 4.5% in Ireland which is the lowest among the countries studied. The UK spent 6.5% in 2014. The spend in Germany is high because patients can refer themselves directly to specialists without recourse to their GP.

When it comes to the per patient spend on general medical practices there is a wide range. Canada again tops the table at 702 USD with Denmark lowest at 206 USD (see comment about the Danish system below). Ireland is second from the bottom at 212.7 USD. The largest private per capita spend on general medical practice is Australia at 144.5 USD with Ireland next at 90.8 USD. In the Irish data the public spend outstrips the private spend by 30 USD per patient which can partly be explained by coverage of a sicker patient population (see below). It is not possible to calculate the proportion of private health spending diverted to secondary care that could be contained in primary care.

Public and private spending on health in Ireland

The funding of healthcare in the various countries we studied is a mix that has been developed from compromises over many years. The more complicated the payments system the more difficult it has been to make sense of the data. Complication also leads to administrative difficulties and costs for the system and the patient.[15]

The overall public and private spend on general practice in Ireland in 2014 was €858.6 million. Payments to GPs amounted to €453 million for medical cards, immunisations and screening.[16] Another €90 million approximately was paid by the HSE for additional fees and allowances, training and out-of-hours supports. The total State payments to general practice come to approximately €543 million or 63% of the entire spend on general practice. Private practice amounts to €315.6 million. This means that 63% of the overall spend is mostly on the 42% of the population who have GMS coverage. It also means that 58% of the population is responsible for 37% of GP income. Private patients consult less frequently than GMS patients – 2.69 compared to 5.63 per year[17]. Recent UK data on 10 million consultations shows GP consultation rates as 3.8 per year and practice nurse rates at 1.36[18].

Private patients are socioeconomically better off and likely to be in better health, which goes some way to explain the disparity in consultation rates. But not the whole way as it is known that the fee is a deterrent to seeing the doctor[19]. While the current system in general practice encourages episodic and acute care rather than ongoing disease management it is important that private patients can avail of any changes to the proactive management of chronic illness. The international funding approach is moving away from out-of-pocket payments as we have in Ireland, towards either tax based, insurance or a combination of both funding systems. This is to develop a system for the delivery of more ongoing proactive healthcare and to enhance equity and access [20].

However changing any system no matter how much it is criticised is not easy. 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 vigour'[21].

Internationally:

Denmark has a universal, tax-based decentralised healthcare system with full population coverage for primary, specialist and hospital care. Approximately 40% (2013) of the population purchases complementary private health insurance as cost sharing[22].

In **Germany** taxes form a central mandatory contribution and insurance is compulsory. Social Health Insurance covers 90% of the population. High earners contribute to private health insurance (other 10%)[23]. Premiums are income dependent but not illness risk dependent. Everyone pays €10 per quarter for first contact with the GP. If patients spend in excess of 2% of household income on medicines, GP costs are waived.

Patients can refer themselves directly to a specialist without recourse to a family doctor, which is a significant driver of costs.

In **The Netherlands** the income-related contribution is set at 7.75% of annual taxable income up to €51,414 (USD 62,224) (as of 2014). Employers must reimburse employees for this contribution, and employees pay tax on the reimbursement.

Since 2006, all tax payers were mandated to purchase statutory health insurance from private insurers. Health insurers are legally required to provide a standard benefits package that includes a wide basket of medical, midwifery, mental health and dental care. It also includes medical aids and devices; prescription drugs; ambulance and patient transport services; paramedical care (limited physical/remedial therapy, speech therapy, occupational therapy, and dietary advice)[24]. The Exceptional Medical Expenses Act covers long-term care, which is increasing in cost.

In **New Zealand**, approximately 38% of the population has private medical insurance. Out-of-pocket spending, at 13% of health spending, has remained stable in recent years and is relatively low compared with some European countries[25]. The prescription charge for each subsidised medication is $5. Prescriptions for children under 13 are also exempt from the standard $5 pharmacy charge for each prescription item from 1 July 2015.

In **Vermont** the Blueprint for Health is a State-led, primary care focused initiative. It is charged with implementing sustainable healthcare delivery reform. It is backed by legislation[5, 26].

- 54% of Vermonters have private insurance
- Over 90% of private insurance is through employer
- 3.7% (23,231) people were uninsured in 2014

Three major types of private insurance exist:

- Employer-based, insured or self-insured
- Individual market (a.k.a. non-group market)
- Federal, state and employer taxes support current healthcare programmes and federal tax credits are available for individuals. For small business firms tax credits are available for two years under the Affordable Care Act 2010[27]

Reimbursement

Table 2 How GPs are reimbursed

	Capitation	Fee per item	Programmes (eg population based screening)	Role of targets/ incentives
Australia	Yes	Yes	Yes	Targets with penalties for non achievement[28].
Canada	Yes	Yes		Activity based funding to improve quality of care[29].
Denmark	Yes	Yes	Yes	Activity based funding[22].
Germany	Yes	Yes	Yes	Sickness funds are required to offer their members the option to enroll in a "family physician care model," which has been shown to provide better services and also often provides incentives for complying with gatekeeping rules[23].
Ireland	Yes	Yes (designated items)	Yes	Immunisation coverage, screening[8].
Israel	Yes	No	Yes	Sick funds initiate programs to improve quality (e.g. monitoring, training, patient education)[30].
Netherlands	Yes	Yes	Yes	Activity based funding to improve quality of care[24].
New Zealand	Yes	Yes	Yes	Activity based funding to improve quality of care. Activities linked to Integrated Performance and Incentive Framework (IPIF)[31].
Scotland	Yes	Yes	Yes	
Vermont	Yes	Yes	Yes	Population health management system[5].

Comment:

Reimbursement is complicated with a mix of capitation and often co-payment fees. General practice is increasingly used for the roll out of population-based measures such as cervical screening and immunisation programmes.

Most systems use incentives for targets with Australia including penalties for non-achievement of targets. The Quality Outcomes Framework (QOF) in the NHS is the most noteworthy for its use of incentives[32], which eventually became 15% of GP income. This distorted the work of general practice with a loss of attention to acute bread and butter care, which led to difficulties in patients getting prompt appointments. Current thinking, based on the QOF experience and a guarded review by the Health Foundation[33] suggests that perhaps around 7% of the overall budget should be incentivised[34].

Internationally:

In **Australia** the role of targets/incentives is pay-for-performance based (GP paid/penalised for not meeting activity or health outcome targets), fee-for-service most common.

In **Canada** primary medical care has traditionally been funded via fee-for-service payments[35]. This includes a service such as a physical examination, immunisation, prescription, etc.

Blended capitation payment schemes are also used in Family Health Networks, Family Health Teams and Family Health Organisations. These systems have a roster of registered patients and the main payment is via capitation: the physician receives a base payment for each enrolled patient; this payment is adjusted for age and sex. Remuneration includes bonuses and incentives for a full-time equivalent 'complement' in a given community/geographic area in addition to overhead payments, locum coverage, continuing medical education, etc. Physicians who are salaried employees of Community Health Centres provide care to a specific identified population.

Denmark has a mixed capitation and fee-for-service system: one-third capitation, two-thirds fee-for-service. The average Dane makes 6.9 visits to the GP annually[36] which is in line with the attendance rate of medical card patients in Ireland.

Germany has a mixed capitation and fee for service system.

In **The Netherlands** GP remuneration includes capitation (37.3% of income) and fee-for-service payment (33% of income). Many GPs employ nurses and primary care psychologists on salary, and the reimbursement for the nurse is received by the GP, so any productivity gains that result from substituting a nurse for a doctor accrue to the GP[37].

To incentivise care coordination, there are bundled payments for some chronic diseases (diabetes, cardiovascular risk management, and COPD), and efforts are under way to implement them for heart failure and depression. There are ongoing experiments with pay-for-performance and population management to improve quality in primary and hospital care[37].

In **New Zealand** general practice now has a blended payment system, with a combination of universal capitated funding, patient co-payments, and targeted fee-for-service for specific items[38].

New Zealand's screening programmes offer:

- More heart and diabetes checks (national target of 90% of the relevant enrolled population)
- Better help for smokers to quit – primary care (national target of 90%)
- Increased immunisation for eight-month-olds (national target of 95%)
- Increased immunisation for two-year-olds (national target of 95%)
- Cervical screening (national target of 80%).

In **Vermont**, leaving the current fee-for-service payments to providers untouched, the Blueprint[26] adds two key payment reforms:

- A ***per Member per Month*** (PMPM) payment made by all payers to primary care providers. They have to achieve a qualifying score on the Patient-Centered Medical Home standards. The PMPM amount depends on the actual score on the standards with higher scores resulting in higher payments. This payment reform incentivises improvements in quality of care.
- ***Capacity*** payments to support the salaries and expenses of the community health teams (CHTs). The CHTs are designed locally by participating primary care providers and area health and human services partners. Typically the teams comprise nurse care managers, health coaches, social workers, and behavioural health clinicians. These multi-disciplinary teams are hired by the Blueprint administrative agents and are deployed to work in the participating primary care practices. The payment is scaled at $350,000 for every 20,000 patients. Vermont's commercial and public payers all share equally in the cost to support the CHTs. The Medicaid portion of this capacity payment is made monthly to a lead administrative agent in each of 14 health service areas. The lead administrative agents are healthcare organisations with strong fiduciary and administrative capabilities, Medicaid enrolled providers, and recognised healthcare leaders in their communities. The payment is based on a quarterly calculation of attributed patients to the participating primary care practices.

Practice subsidies

Most countries offer support to GPs to build teams in line with their primary care strategies. Supporting additional staff in general/family practice made the biggest change to primary care development in Vermont. It provided practices with the opportunity to offer their patients additional relevant services (Jones interview Dec 2016 see later).

2.1.2 IT practices and uses, data

How IT is used in practices

General practices are early adopters of Information Technology (IT) at international levels, which is often supported by governments. Most practices use a secure software package for the recording of administrative, clinical, and prescribing details together with GP and hospital letters. IT is used to provide call and recall for screening programmes and for chronic disease monitoring. Healthmail is a secure clinical email system developed in 2014 for all primary healthcare providers in Ireland, the use of which has increased steadily since then. Of 1542 users, 1487 are GPs. Pharmacies began using the system at the beginning of April 2017. Hospital uptake has been uneven so far. There has been investment in e-referrals in Ireland but links with hospital IT systems are again uneven and under developed and consequently are a cause of concern for GPs.

In Ireland 30% of GPs use email to communicate with patients and texting is used to remind patients of their appointments[8]. Online appointments are not available in most practices. Some GPs express a wish to send electronic prescriptions to pharmacists but there is uncertainty regarding the legality of such a practice. A code of practice does not exist between the two professional groupings. Electronic prescribing has become possible now with the secure Healthmail system.

Information Technology is the basis for preventative medicine such as screening and immunisations. Both these developments have gone well in general practice in Ireland. This is in part because it has been a gradual process that has been carried out with the help of practice nurses[8].

Internationally:

In **Australia** t*he National eHealth Transition Authority* established an interoperable structure to assist in communication throughout the healthcare system. A national *e-health programme* created using unique identifiers is in operation in Australia, with 2.5 million patients and nearly 8,000 providers registered[39]. The database includes prescription information, medical notes, referrals, and diagnostic imaging reports. (See also comment on Australia in section 2.1.7 - Accessibility to GP)

In **Canada** utilisation of health information technologies has slowly increased over the last number of years[40]. Provinces and territories are each accountable for developing their own electronic information systems, with support from *Canada Health Infoway.* Nevertheless, there is no national strategy for implementing Electronic Health Records (EHRs) and no national patient identifier. According to *Canada Health Infoway*, territories each have systems for collecting information electronically for each population. Interoperability, however, is limited. In Canada during 2014, 42% of GPs reported using solely electronic records to document and retrieve clinical records; likewise more than a third (38%) reported using a combination of paper and electronic records. Patients are not able to access personal health record for any function, and in a small number of cases patients have access to an online appointment facility[40].

Denmark is one of, if not the, leading country in terms of the use of IT by its primary care physicians[41]. In Denmark Information Technology is employed at each level of the health system as part of a national strategy supported by the National Agency for Health IT. Every region uses an individual electronic patient record system for hospitals; each region's system adheres to the national standards for compatibility. Danish GPs were ranked first in an assessment of the overall implementation of electronic health records in 2014. Each citizen in Denmark has a unique electronic identifier that is used in all public registries, which includes health databases. Individuals are issued with a combined medical card that may be accessed by each of the applicable health professionals. The card contains encrypted information including prescription and medication use. Furthermore, the GP has access to an online medical handbook with updated information on diagnosis and treatment recommendations. Interestingly, efforts to progress a national clinical database to monitor quality in primary care were terminated in 2015, as it was suggested such databases were found to infringe privacy rights and to imperil the trust between GPs and their patients.

In **Germany** approximately 90% of physicians in private practice use electronic health records (EHRs) to assist with payments, records, tracing laboratory data, and quality assurance. The practice of transmitting payment information online as well as recording disease management programmes is obligatory. Hospitals, however, have employed EHRs to variable degrees. Since 2015, electronic medical chip cards were used nationwide, which encrypt data to the individual's personal information (i.e. name, address, date of birth, and sickness fund) as well as details of insurance coverage and individuals' status in relation to supplementary charges. In 2015, the German Federal Cabinet proposed a bill for secure digital communication and healthcare applications (E-Health Act), which provides concrete deadlines for implementing infrastructure and electronic applications, and introduces incentives and sanctions if schedules are not adhered to. Physicians working with statutory health insurance will receive additional fees for transmitting electronic medical reports (2016–17), collecting and documenting emergency records (from 2018), as well as the management and review of basic insurance claims data online. From July 2018, physicians working with statutory health insurance who do not partake in the online review of the basic insurance claims data will see a reduction in their remuneration. Additionally, so as to safeguard drug therapy, patients who are prescribed three or more medications will receive an individualised medication plan. In the medium term, each medication plan will be included in the individual's electronic medical record.

Patients in **Israel** have an IT system that can bring together information from hospital and community settings. The system facilitates patients to use the internet to access their personal health records, check lab results, schedule appointments, confer with a pediatrician online after regular working hours. Innovative applications in Maccabi, one of four non-profit health plans available to Israeli residents, include those in which patients can enter data from home[42]. They include decision support tools and tele-consultation between specialists in urban centres and patients and their family physicians in the rural areas. A virtual community has developed through which Maccabi's senior management gets ongoing input from a representative sample of its members. This system has been implemented in a system comprising largely independent physicians[43].

In **The Netherlands** the government is attempting to create a central health IT network to permit physicians to share information[24]. Each patient has a unique identification number. Almost all general practitioners have some form of electronic information capacity i.e. they use an EHR and can mandate prescriptions and obtain laboratory results electronically. Currently, all hospitals use EHRs. However, in most cases electronic records are not nationally standardised or interoperable between primary and secondary care. In 2011, hospitals, pharmacies, after-hours GP co-operatives, and organisations representing GPs set up the Union of Providers for Healthcare Communication (*De Vereniging van Zorgaanbieders voor Zorgcommunicatie*), accountable for the exchange of patient information through an electronic system named AORTA; data are not stored centrally[24]. Patients consent to participate and are free to opt out at any time. Access to records is available upon request.

New Zealand has one of the world's most progressive health systems when it comes to IT use among primary care physicians, with almost 100% uptake[44]. The New Zealand government's goal was a universal electronic approach to a basic set of personal health information by 2014[44]. Currently, the work is ongoing with physicians and IT providers working together on several projects. The emphasis is on supporting and empowering integrated care, with a shift towards regional investment decisions and solutions. However, challenges with legacy systems remain (New Zealand, interview with an expert). Increasingly in New Zealand, primary care IT systems offer services such as structured electronic transfer of patient records, electronic referrals, decision support tools with patient safety features, and patient access to health information in a secure environment[44]. There is an imminent emphasis on the facilitation of secure sharing of patient records across community, hospital, and specialist settings, including common clinical information; providing online access to information; thus supporting the development of shared-care plans (in which several health professionals are contributing to an individual's care).

In **Scotland** 2016 changes arising from contract renegotiations mean GP practices must maintain disease registers and code patients based on diagnosis. Practices will also be required to provide appropriate lifestyle advice[45].

Following the American Recovery and Reinvestment Act 2009[46], the **United States** made an investment in excess of $30 billion in IT in healthcare. The legislation started financial incentives for physicians and hospitals to implement EHR systems, under what is known as the Meaningful Use Incentive Program. In 2014, four of five physicians were utilising one form or another of the EHR system. Moreover, 76% of hospitals had adopted at least a basic EHR system, representing an eightfold increase when compared to 2008. The Meaningful Use Incentive Program is intended to raise progressively the threshold for EHR functionality beyond which users obtain incentives and evade penalties[47]. The emphasis is on information exchange.

Data collection in primary care

The IT development in general practice internationally has presented opportunities to collect data to measure what is going on now and to plan for the future. This report has been able to identify considerable amounts of data produced about primary care, but very little generated from within the practices[48]. There is little agreed data about, for example, workload, consultation rates for various illnesses, prescribing and referral rates, generated by GPs themselves. Data for payment is a natural role for IT as is planning future services. However there were no examples of data originating in the practices that shaped the local service provided by GPs.

Canada and Scotland have units that provide a research facility based on GP data. Ireland along with other countries does not have such a resource.

Internationally:

In **The Netherlands** in 2011, organisations representing GPs, after-hours general practice cooperatives, hospitals and pharmacies set up the Union of Providers for Healthcare Communication *(De Vereniging van Zorgaanbieders voor Zorgcommunicatie)*[24]. It is responsible for the exchange of data via an IT infrastructure named AORTA; data are not stored centrally. Electronic records for the most part are not nationally standardised or interoperable, reflecting their historic development as regional initiatives. Patients must approve their participation in this exchange, and have the right to withdraw[24]. The network stores a patient's general practice file and information about use of medications. Patients need to ask a provider for access to the medical file.

2.1.3 Workforce

Table 3 GP workforce in primary care[a]

	Number of GPs	GPs per 10,000 pop	Access to allied health professionals	Admin Staff	Nurses	Average size of partnerships
Australia[b]	34,606[49]	14.2	Yes	2-3	2-3	2-5
Canada[c]	41719[50]	11.6	Yes			85% are 2 or more GPs
Denmark	3,500[51]	6.10	Yes	3	2	
Germany	48,212[52]	6.0	Yes	2-3	2	Mostly solo
Ireland	2,900 (estimate)	6.2		1.5	1	3 or more
Israel	7000[30]	8.1	Yes			
The Netherlands	11,600	6.9	Yes	2	2	3
New Zealand		8.4[53]	Yes	Yes	Yes	Considerable variation
Scotland	4913	9.3[54]	Yes	2	1.5	3
Vermont	348[55]	5.5	Yes	2-3	1-2	4-13 GPs (varies greatly) + internal medicine physicians

[a] Numbers of GPs are based on absolute numbers and not whole time equivalents (WTE). They relate to latest figures avaialable, thus data for some countries are older than others

[b] Figures for GP in Australia fluctuate greatly between regions http://www.health.gov.au/internet/main/publishing.nsf/content/General+Practice+Statistics-1

[c] Refers to General Practitioners/Family Physicians

GP Workforce: Limitations of the data

Data are based on the absolute number of GPs available within the international literature. We do not know how many of these are full or part time. GPs in wholly private practice are not usually captured in workforce databases as is the case in Ireland. A review of the PCRS data for 2015[14] shows 2,432 GPs holding a GMS contract which involves a whole time commitment (WTE). In 2015, 76% of GPs in Ireland reported working 7 or more sessions per week in their practices[8]. Another group of 457 GPs who do not hold a GMS contract, hold a publicly funded contract for programmes such as the Primary Childhood Immunisation Programme. The WTE commitment of this group of GPs is unknown. This gives a total of 2,889 GPs with State contracts in 2015. The recent Health Service Executive report estimated that there were in total some 3,923 doctors working in General Practice in the Republic of Ireland[56]. It draws its figure from the Medical Council register, the ICGP database and the HSE PCRS contract holders. The Medical Council database is likely to contain GPs who are not working, are away or who are training in other disciplines but who are maintaining their names on the register with a view to returning to practice in Ireland or to mainstream practice. The ICGP database will contain GPs who are working as assistants and those who may be working in posts allied to general practice but not in general practice. Based on these calculations there are over 1,000 GPs who cannot easily be accounted for. The Trinity/ICGP study estimated that 11% of practices were private only. The same study estimates that there were 2,932 GPs in practice in 2015[8].

Comment:

While the number of GPs in practice in Ireland is not agreed, the figure of clinically active GPs is likely to be under 3,000. In a workforce review of future demand for GPs, the HSE concluded that there will be a significant undersupply over the next ten years. This undersupply is based on the high estimate of the number of 3,923 GPs. The shortage will range from 493 to 1,380 GPs by 2025. The shortfall will depend on the role the GP plays in the health service – the greater the role the more GPs needed[56].

Workforce is a complex area that is important, but difficult to predict future needs. All workforce predictions now add qualifications about the data. We do not know which doctors are full time or part time and which are male or female. GPs, both female and male, are working fewer hours and sessions[8]. The data do not reveal how many patients they see and what those patients suffer from. Assuming the limitations of the data are broadly consistent for each country we can give an indication of the ratio of GPs for each population. It is expressed here as number of GPs per 10,000 people.

Countries that are rated highly on global primary care measures like access and services, such as Canada, Australia and Scotland, have up to 50% more GPs per 10,000 people than Ireland and other weaker primary care countries. The Netherlands, with slightly more GPs than Ireland, is the exception, as it has a GP system that is rated strongly[4]. Noticeably the research shows that The Netherlands has a higher number of practice based staff. Ireland has the lowest practice based staff ratio in the countries we studied.

Even the countries with a higher proportion of doctors are short of family physicians. Increasing need arises from multiple factors including population age, multiple chronic illnesses and the higher expectations of patients. GPs increasingly say working conditions also play a part, with a good career structure and having colleagues to share workload and responsibility being major factors in attracting doctors into general practice and in retaining them. Our GPs in training (Section 3.9 of this document) confirm these reports.

Substantial variation concerning education, tasks, remuneration and terminology of AHPs may be found in primary care internationally. While there is access to allied professionals this varies greatly, particularly within larger countries such as Canada where access is regionally dependent and sometimes unequal. Nevertheless, the number of AHPs and support workers, such as medical assistants, working in primary care, is steadily increasing.

Primary care services in some OECD countries are evolving to include multidisciplinary group practices or networks (where GPs work alongside other allied health personnel, such as hospital doctors, dental professionals, pharmacists, clinical psychologists or podiatrists); or multi-sectoral group practices or networks (where GPs also work alongside specialists from fields beyond clinical care, such as long-term care, social welfare, training and employment, or criminal justice).

Internationally:

Denmark is making strong efforts to focus their system on primary care[57].

Germany has a shortage of GPs - working conditions are perceived as poor and thus fewer younger doctors opt for GP as a career[58]. There has been a drive to recruit foreign doctors in the past 5 years. This has had modest effect. Eighty seven percent of GPs in Germany are self-employed with 13% being salaried.

In **New Zealand**, with reform, there has been a shift in trend from solo to predominately group practices. There has been a similar shift in Ireland over the last 30 years with only 18% of GPs being singlehanded now. There is a current target for 50% of New Zealand medical graduates to enter general practice, however recruitment is falling short of this by far.

Scotland has many clusters of deprivation and patients from more deprived areas tend to be high-end users of health services[59]. There is a shortage of GPs in these areas.

In **Vermont** almost half of the family medicine physicians limited or closed their practices to new patients in 2012.

2.1.4 General Practice Training

Table 4 General Practice Training

	Length of course	Amount of time in general practice
Australia	3 years	18 months
Canada	2-3 years (3rd specialist year palliative, care of elderly etc.)	Residency in Family Practice
Denmark	6 years postgraduate (1 general)	5 years
Germany	5 Years	18 months
Ireland	4 years	2 years
Israel	4 years	2 years family medicine
The Netherlands	2-3 years	20% per year
New Zealand	3 years	18 months
Scotland	3-4 years	Approximately 1.5 years
Vermont	3 years	18 months

Comment:

Ireland does well in terms of providing well-trained GPs with good exposure to specially designated training programmes and practices. In 2016 €25.5 million was spent by the HSE on the future training of GPs. Numbers are being expanded in response to need. Integration with university departments of general practice occurs in Denmark and in one training scheme in Ireland. In another part of this report the issues behind the vision and expectations of GPs in training are described.

Internationally:

In **New Zealand** there is 10 months of basic vocational training (General Practice Education Programme) with specialist placements over 26 months.

2.1.5 Chronic Disease Management

Most countries are grappling with chronic disease management and some have included it as part of the overall contract while others have separate contracts for specific diseases. Care is usually GP or nurse led. A modern chronic disease system uses IT to develop a register of patients, issue recalls and reminders and for medicines management. Those chronic illness systems in operation are nurse led with designated time. The nurses interviewed for this report showed a willingness to engage in the care of patients with chronic illnesses.

There is a fuller discussion of long term care later in this report.

Internationally:

Australia has made several advances to improving integration and care coordination such as the Practice Incentives Program, which provides a financial inducement to physicians to develop care plans for individuals with particular illnesses (asthma, diabetes, and mental health needs). Moreover, the Australian government developed *Primary Health Networks* in July 2015[60] to work directly with primary care physicians and other specialists in order to improve coordinated care for those at risk of poor health outcomes. Care is also coordinated by Aboriginal health and community health services.

Provinces across **Canada** have established a number of initiatives to improve integration and coordination of care for chronically ill patients with complex needs; including the Divisions of Family Practice (British Columbia), the Regulated Health Professions Network (Nova Scotia), and Health Links (Ontario)[40]. Likewise, in Ontario there are specially funded alternative community-based and multidisciplinary primary care models to serve specific populations (the elderly and individuals with disabilities, including health and social care services e.g., supportive housing and meal delivery programmes). Specific provinces have employed incentives to support physicians to deliver *guideline-based care* for chronic disease. An example is Ontario's Diabetes Education Programs employing teams of diabetes education nurses and registered dieticians to encourage patients and primary care physicians to implement guideline-based diabetes care[29].

In **Denmark** there are mandatory health agreements between cities and regions to coordinate care and tackle a number of matters regarding admission and discharge from various health settings (hospitals, rehabilitation, psychiatric care) as well as prevention, IT support systems, and outcomes. Agreements are formalised and must be approved by the Danish Health Authority. The agreements are partially supported by IT systems with shared data between the various providers of care. The outcomes for the regions are measured by national indicators, published online[61].

Regions have developed a number of measures to support continuity of care e.g. hospital outreach teams to follow-up patients at home; training for nursing and care staff; establishment of municipal units located within hospitals to facilitate communication, particularly in regard to discharge; and the use of 'general practitioner practice coordinators'. Several of these initiatives have a special emphasis on citizens with chronic care needs, multi-morbidity, or frailty due to aging or mental health issues. GP practices increasingly employ specialised nurses, and a number of regions provide financial incentives to develop multispecialty facilities known as 'health houses'. Various models exist but mostly include GPs, practicing specialists, and physiotherapists, among others. The GP is encouraged to act as coordinator of these *medical homes* with the view to developing comprehensive care plans in terms of prevention and care. This principle is commonly accepted and is supported by national level agreements between GPs and regions. The GP partakes in numerous formal and informal network structures.

Germany has made numerous efforts to improve care coordination, e.g., sickness funds, which offer *integrated care contracts* and disease management programmes to advance care for chronically ill patients and to improve management between providers in the ambulatory services. In December 2014, 9,917 registered disease management programmes for six indications registered more than 6.5 million patients (over 8% of all those insured by statutory health insurance)[23]. There were no shared funding streams for health and social care sectors. However, from 2016, the Innovation Fund serves to promote innovative methods of cross-sectoral and combined care with annual funding of EUR 300 million, or USD 381 million (including EUR 75 million, or USD 95 million, for evaluation and health services research).

In **Israel** health plans, which include insurers and providers, are essentially the sole source of primary care and the central basis of specialty care. This operational integration of services provides the basis of service provision of a *relatively seamless care for all the insured*, including complex and chronically ill patients. The plans' health information systems are interconnected to both primary and specialty care, and the national health information links the health plans and the hospitals[48]. Increasingly these provide access to electronic medical information at the point of care. In addition, the health plans have put forth several targeted management programmes that aim to provide comprehensive integrated care for complex patients with chronic conditions. More generally the integration of care is limited among the different components of the long-term care system and between other components of the healthcare system.

In **The Netherlands** a national bundled-payment method is applied to chronic care for diabetes, COPD, and cardiovascular risk management[62]. Within this system, insurers reimburse a single fee to a principal contracting entity—the care group, which covers a full range of chronic disease services for a fixed period. This *bundled-payment* method succeeds conventional healthcare purchasing for the condition dividing the market into two components, - one where health insurers contract care from physicians, and a second where the physicians contract services from individual providers. Both are negotiable fees[63]. To further supplement coordination and better extend to vulnerable patients, the role of district nurses is currently being strengthened.

Across **New Zealand** Integrated Family Health Centers have been established in line with the "Better, Sooner, More Convenient" government policy. The objective of this is to improve access to integrated care provided by district health boards and primary health organisations by creating additional locations for patients (outside of hospital settings) and by emphasising chronic disease management[44]. The New Zealand government is fast tracking the initiative for clinical integration in order to construct a more patient-centred health system by ensuring that all District Health Boards' annual plans incorporate schemes for integrated care. These guidelines have been advanced by a new 2013 Primary Health Organisation contract. There is significant opportunity for these alliances to integrate health and social services, moreover, there has been a progressive shift towards shared funding streams. For example, specialised providers contracted by the government to address vulnerable populations, such as Maori and Pacific people, work to coordinate health and social services.

2.1.6 Out-of-hours services

Table 5 Out-of-hours care

	Is there a system?[48]	Run by GP's own practice?	Deputising service?	Reliance on ED?	How is it remunerated?
Australia	Yes	Yes	Yes		
Canada	Yes	See comment			
Denmark	Yes	See comment		No	
Germany	No info				
Ireland	Yes	Occasionally	Yes	Yes	See comment
Israel	Yes	No	Yes	Yes	See comment
The Netherlands	Yes	See comment			See comment
New Zealand	Yes	See comment			See comment
Scotland	Yes	See comment		Yes	See comment
Vermont	Yes	Yes			

Comment:

Out-of-hours care seems to be designed in or out of the various systems we studied. Ireland has utilised the long history of the co-operative movement to build an effective GP response to out-of-hours. Approximately 93% of GPs are now part of an out-of-hours co-op[8]. They now provide over 1 million out-of-hours consultations per annum and have high satisfaction levels (see patient feedback later). Remuneration is through private fees and Special Type Consultation fees which amount to €34 million per year. The HSE contributes €40 million a year to running costs of some Co-ops. An HSE review of Co-ops is ongoing and will report later in the year.

Internationally:

In **Australia** some practices use their own GPs to provide care, or alternatively use a local cooperative of GPs or a medical deputising service.

In **Canada**, there is a regional GP rotation system.

In **Denmark** also, out-of-hours is organised by region - GPs participate on a rotation basis.

In **Israel**, out-of-hours care is available via hospital emergency departments (EDs), freestanding walk-in 'emergi-centers', and companies that provide physician home visits. Physicians providing care in EDs and emergi-centers come from a range of disciplines, including primary care, internal medicine, general surgery, orthopedics and, increasingly, emergency medicine. Nurses play a significant role in triage[48]. They are typically salaried, while physicians working for home-visit companies are typically paid per visit.

Primary care physicians are not required to provide after-hours care. They receive reports from the after-hours providers, and increasingly this information is conveyed electronically.

All the health plans operate national telephone advice lines for their members, which are nurse-staffed with physician backup.

In **The Netherlands**, out-of-hours primary care is organised at the municipal level in general practitioner (GP) 'posts'—centralised services typically run by a nearby hospital that provides primary care between 5pm and 8am. Doctors are compensated via hourly rates for after-hours care and are required to provide at least 50 hours out-of-hours care annually for continuation of registration as GPs[24].

New Zealand's out-of-hours system is regionally organised by health boards, which are also responsible for remunerating service providers.

In **Scotland**, the service was recently renegotiated - NHS delivered.

2.1.7 Scope and accessibility of general practice

Accessibility to GP

Table 6 Accessibility to GP

	Prompt appointment[a]	Experienced financial access barrier (in past year)[b]
Australia	58%	16%
Canada	41%	13%
Denmark	Unknown	Unknown
Germany	76%	15%
Ireland	Most patients – See Coyne Research 2017	26.3% paying patients 4.4% GMS Ref 19
Israel	Unknown	Unknown
The Netherlands	63%	22%
New Zealand	72%	21%
Scotland/UK	52%	4%
Vermont	48%	37%

[a] Each of the above countries (unless otherwise stated) has access to GP same or next day[48]. Access to specialists in case of both Scotland and Vermont are cited in terms of the overall UK and US respectively.

[b] Each of the above countries (unless otherwise stated) expressed financial access barriers to GP[48].

Comment:

Even in countries with exemptions for the poor and more vulnerable, a consultation charge can deter a large proportion of patients who are just above the limit from seeing their GP. They are likely to be the less well off and be less healthy with over a quarter of private patients in Ireland putting off a visit to the doctor because of fees.

Internationally most doctors operate by appointments. There is evidence of IT being used to facilitate appointments made directly by the patient and extensive telephone availability.

Patient feedback shows high satisfaction with accessibility to the GP in Ireland (see later section).

Internationally:

In **Australia** there is a system of shared medical records. Core clinical information must initially include:

- medications;
- allergies and adverse reactions;
- discharge summaries;
- recent results of pathology and diagnostics imaging tests;
- recorded clinical observations such as height, weight, blood pressure; and
- advance care directives, advance care plans and resuscitation plans.

At the time of writing (late 2016) a universal, automatic and effective incentive for all clinicians in shared care to participate in shared Electronic Medical Records (EMRs) was planned[28].

Denmark's GP appointment system is fast and easy. There is a governance rule - any patient must be seen in 5 days or less.

In **New Zealand**, issuing prescriptions by electronic means only does not meet the current New Zealand legislative standards.

GP access to diagnostics and hospital specialists

Well functioning GP systems have good access to the laboratory and to radiology. In the Netherlands, Canada and Denmark 50%, 53% and 60% of GPs respectively have access to MRI investigations. Radiology is an ongoing issue with evidence of deterioration for public patients in Ireland[8]. MRI is available if the patient is able or willing to pay. Electronic laboratory access is good in Ireland.

Again the aim of well functioning primary care systems internationally is to work with hospital specialists in a timely manner using electronic and phone methods to talk to each other. While this happens in Ireland it is a general source of complaint for GPs that most communication occurs with junior staff with limited influence in the system. The impact of the public / private divide aggravates accessibility and has been well and often described. There is telephone and electronic advice available to GPs in other healthcare systems but it is not possible to quantify the amount of the advice.

2.2 Conversations With Three Key International Experts

In December 2016 and January 2017, in-depth interviews were undertaken with leading experts from three of the nine countries in the report, *viz* New Zealand, Scotland and Vermont (USA).

Rationale for selection

New Zealand has a similar population to Ireland and a broadly similar healthcare culture. We examined a network called Pinnacle which has a not for profit organisation of 500 GPs from a variety of backgrounds. The network provides support with staffing, finance and IT. It is expansionist in its outlook.

Scotland has a similar population and healthcare culture to Ireland with a similar geographic spread of densely populated urban areas and areas of remoteness with limited access to health services. It is undergoing primary care reorganisation and a clearer and leaner definition of the GP role is emerging.

Vermont in the US has had to develop primary care from a very low base in a strongly hospital dominated system. In order to do this it has legislated for a primary care approach and has published evaluation of its progress.

International experts

New Zealand - John Macaskill-Smith, CEO Midlands Health Network
Midlands Health Network together with Pinnacle, works with the Midlands Regional Health Network Charitable Trust and other key partners to achieve sustainable delivery of primary and community healthcare services to nearly half a million people enrolled with almost 100 practices in the Midland region of the North Island in New Zealand. The Pinnacle network of like-minded GPs and health professionals is the provider interface for healthcare in the community. Its members play a crucial role in achieving better healthcare outcomes. The general practices work together to take advantage of the benefits that size can provide. Pinnacle is a well established network and has a reputation for high quality healthcare locally, nationally and internationally.

Scotland - Alan McDevitt, GP
Dr Alan McDevitt is a GP in Clydebank. He has been Chair of the Scottish General Practitioners Committee since August 2012. A new GP contract is due in 2017 and Dr McDevitt is currently working with the Scottish Government on what this will entail.

Vermont - Dr Craig Jones, until recently worked for the State of Vermont as the first director of the Blueprint for Health.
Craig Jones, MD is the former Director of the Vermont Blueprint for Health, a programme established by the State of Vermont, under the leadership of its Governor, Legislature and the bi-partisan Health Care Reform Commission. Launched in 2003, the Blueprint is intended to guide a comprehensive and statewide process of transformation designed to reduce the health and economic impact of the most common chronic conditions and focus on their prevention. Dr Jones currently practices as a Family Physician specialising in paediatrics, in Los Angeles, California.

We asked four core questions of each expert:

1 What works well in your system?

2 What needs to change?

3 What should be done differently?

4 What is the one thing that you would change if you could?

In the following interview responses, each country is identified under each question.
The conversation sections are faithfully reported. All contain rich ideas and are worth considering.
We have reduced lengthy transcripts to the following key points.

1 What works well?

New Zealand: *"...it's owned and governed by groups of GPs" "...a really useful layer in the health system that's close enough to general practice and community providers to really understand what small cash-based businesses look like."*

Scotland: *"That we are going back to – as you would say – and it is a more traditional defined clinical role"*

Vermont: *"...legislation was a game-changer for us..." "...there was the team-based services, emphasis on management and prevention, use of health information technology..." "We have ... a series of layers to guide the transformation effort but what you really needed was the payment model that would support it."*

2 What does not work well?

New Zealand: *" … hospitals in New Zealand have ... produced a deficit of about 230 million ... they've offset that deficit in the hospitals by retarding or not investing in community and primary care to the same amount .... what we're starting to see is primary and community services shrinking as the hospitals' over-consumption of the resources kind of kicks in".*

Scotland: *"...the QOF programme[64]... very successful ... but unfortunately there was good – fairly good evidence that if you were in QOF, you were neglected, so other areas went down when you went up... "*

Vermont: "*... one of the biggest challenges, is the data and information – you can't do this without measurement and information coming back ... There has to be a positive, constructive, engaging opportunity, you let people engage when they're ready ...".*

3 What should be done differently?

New Zealand: *"... it's going to become harder and harder to attract people into becoming a generalist and dealing with the vast array of things that GPs have to deal with..."*

Scotland: *"So we're saying 'We don't want – we want to decrease the risk of being a GP' - and this is attractive to young doctors, that you don't have to employ staff to direct, we're currently talking about a concept of secondment that the NHS will employ staff on secondment to the practice..."*

Vermont: *"..frankly, the team needed to be more oriented toward the non-traditional medical things… you needed social workers, you needed the behavioural health experts and counsellors, you needed dieticians..."*

4 What is the one thing you would change if you could?

New Zealand: *"I mean our biggest frustration is still the bottleneck we experience when we're trying to access advanced diagnostics or some of the specialist kind of input and, you know, we're faced with a very traditional hospital mentality. We would like to ideally move a lot of the outpatient services away from the hospital and start running them whether they're primary care setting even being led by primary care"*

Scotland: *"Secure GP pay and take the risk out of it, ..."*

Vermont: *"... a shared savings approach where hospitals work with primary care to improve the health services in their local area, their community"*

Comment:

The interviews with the three experts showed contrasts.

The well-established and better-funded Scottish system wants to focus on a more traditional leaner GP role that can cope with forthcoming reductions in spending.

In New Zealand the Pinnacle network gives a strong sense of ownership to the GPs and is in expansionist mode[65]. In Vermont, being data driven is vital to demonstrate that primary care is working and is saving money. It has taken an overtly political approach to the process. Like the system in North Carolina[66], which is also relatively new, they have achieved quick wins that are not as clear in other long established systems. These wins are evident through their collection, use and analysis of their data.

Part 3

National Evidence Review

3.1 Service Users and Service Providers

Feedback from general population, patients, GPs, newly trained GPs, pharmacists, nurses, representatives from allied health professions, a private health insurer and hospital consultants.

The National Evidence Review - ***Building a better GP and Primary Care Service - Research Findings from Service Users and Providers*** - was commissioned by the HSE and carried out by Coyne Research. The authors of the current report were supplied with the outcomes of the Coyne quantitative and qualitative research and have summarised the findings below. The full findings of the Coyne research are available on the HSE website.

This website will also contain a link to the HSE Research and Engagement Overview.

Views were sought from the general population, GPs, newly trained GPs, hospital consultants, nurses, representatives from allied health professions, pharmacy representatives and a private health insurer. This was to gain a better understanding of the current system from the viewpoint of both patients and those working in the system.

The authors of the current report also conducted a focus group with two groups of GP Trainees from two different training programmes, reported in section 3.10.

3.2 Research Methods

3.2.1 Quantitative research

The quantitative research comprised a nationally representative sample of the population in Ireland and was of 1,010 standardised telephone questionnaires. Additionally, a public online survey took place on the HSE website. This comprised a self-selecting sample of all members of the public and generated 5,085 responses over a 2-week period. The two populations will be referred to as the nationally representative survey and the public (online) survey in this report.

3.2.2 Qualitative research - focus groups and interviews.

Four focus groups, as detailed in the table below, were conducted among those who had used the GP service in the last 12 months.

Focus groups breakdown

Source: GP Services Research - Service Users and Service Providers report; Coyne Research, January 2017

	Segment	Age	Gender	Social Class*	Location
1	Younger, No Children	20-35	Mixed	ABC1	Dublin
2	Young Family (Children Under 6)	30-45	Females	C1C2	Cork
3	Mix Childern/ No Children	35-55	Males	C2DE	Dublin
4	Mix Childern/ No Children	65+	Mixed	C2DE	Cork

*Social class defined by occupation of the chief income earner.

ABC1 = Higher, intermediate, supervisory, clerical or junior managerial, administrative or professional.

C1C2 = Supervisory, clerical or junior managerial, administrative or professional, or skilled manual workers.

C2DE = Skilled manual workers, semi-skilled and unskilled manual workers, casual or lowest grade workers, pensioners, and others who depend on the welfare state for their income.

The interview part of the research included general practitioners and consultants, nurses, representatives of allied health professions, two pharmacy representatives and a private health insurer. The GPs were Dublin and rural-based and the consultants came from a range of disciplines relevant to general practice.

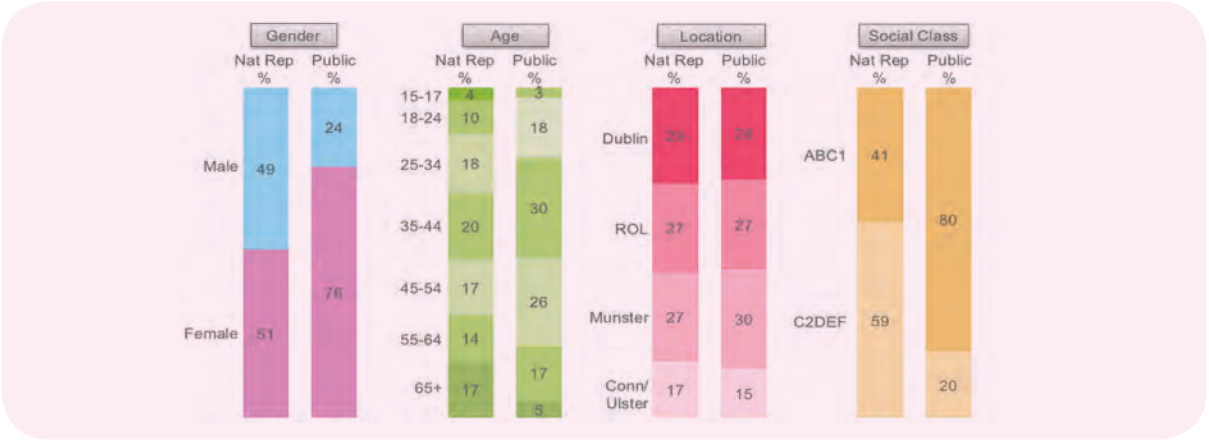
3.2.3 Sample profiles

The two samples – the representative sample and the online sample generated a noticeably higher proportion of older females from the ABC1 category. The ABC1 social grouping ranges from upper to lower middle class and comprises half the population.

Just over 1 in 3 of both samples have children. Two in 5 of both samples had access to free GP care. The majority of the population had a family GP with 4 out of 5 visiting a group practice. Those who visited their GP in the last 12 months were more likely to be female with children and were from the ABC1 category.

Sample Profile

Source: GP Services Research - Service Users and Service Providers report; Coyne Research, January 2017



Note: ROL refers to Rest of Leinster

3.3 Interaction With GP Services

3.3.1 Satisfaction levels

Overall, 90% stated they had been satisfied with their last GP visit, with 2 in 3 from the representative sample claiming to be very satisfied. Satisfaction was slightly lower among younger age groups living in Dublin without a medical card. Those most satisfied had free access to the GP, were generally older and had positive personal experiences with the GP who was easy to access. A personal relationship with the GP came through consistently as a key factor in positive experiences.

Four in 5 patients of both populations who had visited the GP in the last 12 months found it easy to get an appointment. Over 4 in 5 were able to access the GP within 24 hours for urgent care.

Level of satisfaction with visit to GP within last 12 months

Source: GP Services Research - Service Users and Service Providers report; Coyne Research, January 2017

Home visits are still a feature of general practice in Ireland with small proportions of both samples, 2%, receiving a home visit.

Both samples were well aware of GP out-of-hours services and used them frequently. Accessibility was rated highly, with 1 in 2 of the representative sample stating that opening hours were very good. Satisfaction with out-of-hours was also highly rated.

One in three of the nationally representative sample had previously decided not to go to the GP because of cost. As expected, this was highest amongst those paying for the service and the younger age cohorts.

3.3.2 Ease of access

Most patients find it easy to find a GP, with patients being prepared to go on a waiting list for a recommended GP.

Overall ease of access for appointments with the GP was rated highly. Parents of children commented on being given priority and same day appointments were available for the majority. Walk-in clinics were more likely to be used by young, single patients. Many patients referred to the flexibility of individual doctors in seeing them, including after 6pm or fitting them in first thing in the morning.

From recent experience, GP facilities with regard to cleanliness and discretion of the staff were rated highly. However, 10% made unfavourable reference to the amount of time waiting to see the GP.

3.3.3 Communication with the GP

Quality of communication with GPs is rated highly with regard to understanding the diagnosis, treatment plan and medication instructions. Patients feel that they were given adequate attention and commented favourably on the questions asked by the GP, the listening skills, and the interest in their case.

The majority of both samples considered that the GP visit provided value for money, with 1 in 4 claiming there was room for improvement. The more established the relationship was with the GP, the more likely the patients were to say they had received value for money. Trust in their GP and the service provided was the main driving factor.

Patients were acutely aware of the services currently provided by their GP. These included blood tests, blood pressure monitoring, vaccinations, lifestyle advice, men's and women's health, STI screening, antenatal and postnatal care, and minor surgery.

3.4 GP and Consultant Interviews

These interviews assessed the general relationship, communication, and access between the consultant and the GP. Resources inevitably dominated these discussions. The GPs felt they required more training, more staff, and more funding in order to be able to deal with the increased complexity of cases that they saw. Increased demand was focused as a result of the recent under-6 contract which was seen as driving demand in the practices and in the out-of-hours service.

3.4.1 Technology and referrals

Technology loomed large in the comments of both GPs and hospital consultants. The Primary Care Reimbursement Service (PCRS) came in for criticism and was seen as in need of modernisation. Both GPs and consultants recognised that the current financing structure needed to be addressed in order to improve the service. There was recognition that the GP contract needed modernisation.

The referrals process was explored in detail. It remains a bugbear for GPs. While fax referrals were considered outdated, they still continue. Electronic referral processes are not in place universally, but were supported by GPs and consultants. This was seen as important for non-emergency patients and for diagnostics.

For urgent cases, the GPs are forced to refer patients through the emergency department regardless of the condition. GPs were often aware of the exact diagnosis but could not refer directly to the relevant department. The opinion of the consultants and the GPs was that this is contributing to hospital overcrowding. The inability to refer patients directly for diagnostics, such as x-rays, adds unnecessary steps and costs for patients, GPs, and the hospitals.

Both GPs and consultants supported a single electronic referral pathway which could be logged and confirmed and would be traceable. This could easily be followed by an update of when the appointment is available. It was recognised that equipping the current IT systems with an e-referral system will add costs and it was seen as important that this is provided by the HSE.

3.4.2 Diagnostics

GPs were realistic about the availability of diagnostics and understood that a system would be needed for priorities. It was understood that some tests were of a specialist nature and would not be considered appropriate for general practice. They supported guidelines to prevent unnecessary use.

The heart failure clinic was seen as a model that enabled GPs to discuss specific cases with consultants. It was felt that a teleconference set up for consultants and GPs to share information and knowledge on complex patients could borrow from the heart failure initiative.

Healthmail is a current email system that enables secure transfer of clinical information. Some technology-adopters have embraced this form of communication. However, not all GPs and consultants are registered, and this was seen as driving inconsistencies in communications.

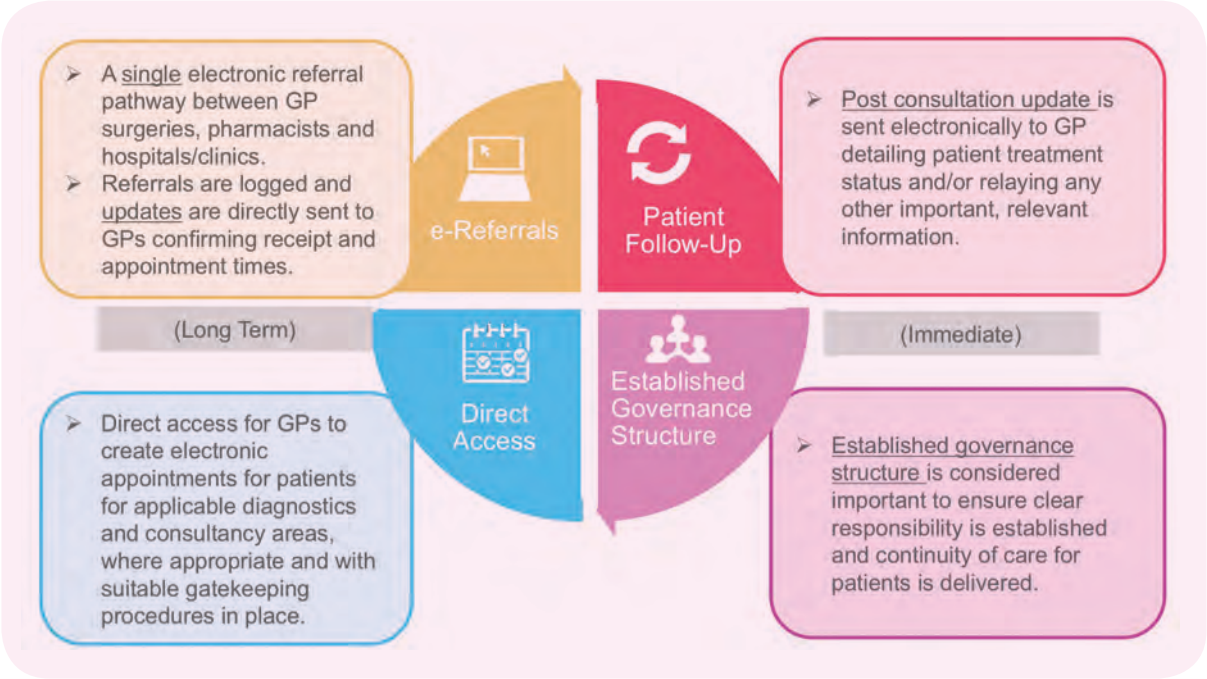
3.4.3 Unique patient identifier

A unique patient identifier is considered to be an important initiative that will have positive results for GPs, consultants, and patients. It will save time on the back and forth communications between consultants and GPs and will be beneficial in emergency and out-of-hours situations where pre-existing conditions and medications can be identified.

3.4.4 Overview of preferred referral system

Diagram of preferred referral system

Source: GP Services Research - Service Users and Service Providers report; Coyne Research, January 2017



3.4.5 Chronic disease management

Chronic disease management was seen to be of increasing importance by both GPs and consultants. Both groups supported more chronic disease care in the community and delivered in the GP practice. Patients without a medical card were seen as being particularly disadvantaged and were more likely to go to a hospital for their procedures where they are available free of charge, but subject to inpatient charges.

There were a number of examples of services that were working well or could work well over time. These included the Midlands Type II Diabetes Structured Care (http://www.lenus.ie/hse/handle/10147/621484) and Heartwatch programmes.

3.4.6 Ideas for change

There were a number of ideas between GPs and consultants for areas of improvement. These included financial support of new services for chronic diseases including training, and advice from specialists. Also, mental health, with a focus on lifestyle improvements, was seen as an area in need of resources.

Nursing home care is a frequent concern for both GPs and consultants, with calls to reinstate the higher nursing home capitation payment to make the service viable.

GPs are in favour of a co-payment system for each visit in order to deter what are seen as unnecessary visits. This was likened to the prescription charge or the plastic bag levy, which were seen as successes.

3.4.7 The health insurer

A small number of GPs referred to engaging private health insurers in the management of chronic disease services. Non-GMS patients with chronic illness go to secondary care, private and public institutions to avoid payment at the GP. GPs felt that private health insurers needed to work with the HSE in order to drive change. Systems in Australia and Canada were highlighted to support an insurance approach.

The private health insurer recognised that primary care has a much larger part to play as the population is getting older with more complex illnesses. Again, the private health insurer referred to Germany as an example of where the regulatory market encourages insurers to fund chronic disease management in primary care[67]. The regulation of the current market is seen as a significant obstacle in funding chronic disease management in primary care.

3.4.8 Practice nurses

Practice nurses were considered to be central to the delivery of high quality care and in ensuring continuity of care. Both GPs and consultants saw the practice nurse as ensuring that GP time was spent efficiently. Good practice nursing was seen as reducing pressure on hospitals and public health nurses. It was recognised that the nurse's remit varied depending on their training. The lack of adequate funding for practice nurses and also the funding of time to upskill and train them was seen as an obstacle. It was also noted that GPs were in competition with the HSE in providing attractive packages for nurses.

3.4.9 Practice management

All GPs valued the role of their practice manager. Having a practice manager was seen as freeing up GPs' time from administrative duties. However solo practices were seen as being disadvantaged in employing a practice manager because of their size.

The key administrative issue for the GPs was with the Primary Care Reimbursement Service (PCRS). The processing of claims was seen as complicated, lengthy, and inefficient on occasions.

3.4.10 Continuity of care

The issue of continuity of care, where the patient saw the same doctor or nurse, came up frequently in GPs' and consultant interviews as well as the health insurer's interview. All patients would prefer to see the same GP for each appointment, but this was not considered to be a necessity. All saw continuity of care as important for older patients and those with more complex illnesses. Older patients were more likely to have an established relationship with the GP, and they also favoured continuity of care.

Both GPs and hospital consultants saw the value of working in a primary care team. This was particularly seen as improving continuity of care, reducing referrals into secondary care, and having readily available advice such as a psychologist for mental health.

3.4.11 Training and the GP Contract

Training came through as a strong theme for GPs, particularly in being able to release nurses for courses that would be of benefit to patients. The lack of finance, training, and replacement staff were seen as obstacles.

Trainees and new GPs all referred to keeping newly qualified GPs in Ireland for the duration of their career. This was seen as a particular problem for rural practices, which struggle to attract new members of staff. There is a perception that the current GMS contract is inflexible and excludes qualified doctors who would otherwise be interested in providing general practice. In particular, despite being in place since 2014, having no job-share or contract-sharing provision, was reported as an obstacle. The issue of finding locums, particularly in rural areas, is seen as a difficulty, which causes distress for rural GPs.

3.4.12 Development of additional services

When it came to additional services, over 1,000 patient respondents made suggestions for additional services in their general practice. Top of the list were mental health services, followed by x-rays on site, minor surgery, blood tests and lifestyle advice.

Patients were keen for the majority of their healthcare to be conducted in general practice and again indicated their high level of trust in the GP as a driving factor. The importance of avoiding hospital visits was high on patients' minds.

While the availability of the practice nurse differed between practices, patients' comments about the nurse were universally positive. They were seen as costing less than a GP visit and it was felt that the nurse took pressure off the GP.

While patients wanted more mental healthcare from their own GP some thought it should be part of the standard consultation. However patients realised that good mental healthcare could not be possible within the current appointment times.

3.5 The View Of Nurses

Interviews took place with practice nurses, public health nurses and a diabetes community nurse. The availability of resources for patients was linked to funding at practice level. Practice nurses have positive experiences of working with primary care teams especially if they have regular clinical meetings. Having HSE staff in close proximity was seen as helping good working relationships.

There was satisfaction with the new diabetes programme with practice nurses seeing it as an important start in the management of chronic illness. Practice nurses thought that it could become the template for the management of other chronic illnesses. The diabetes nurse was interested in an educational approach as part of a programme of care.

Practice nurses wanted to see more incentivisation of chronic illness management for practices and saw such care as keeping patients out of hospital. They saw themselves working with HSE nurses and are interested in joint training sessions especially in mental health.

All the nurses mentioned the variability in practices when it came to availability, communication and levels of interest. Access to an electronic patient record both in general practice and hospital was seen as a way to improve care and efficiency.

The increase in mental health issues put additional strain on both the practice nurse and GP with requests for additional support and training coming from the practice nurses.

Practice nurses value their, often longstanding, relationship with the local pharmacist and commented on its importance in ensuring continuing safe care for patients especially in answering queries about medications.

In addition to more chronic illness, practice nurses requested additional training in wound care and health maintenance and prevention.

The Irish Nurses and Midwives Organisation (INMO) in a recent submission see an expanded nursing role in the area of triage in GP out-of-hours. Triage is a system that decides on the urgency or severity of conditions presenting for medical attention. Such a system is currently in place in some out-of-hours Co-ops. The INMO recommends the establishment of a national telephone triage system with inbuilt decision support systems.

The INMO advocate the integration of practice nurses into all community nursing services. They recommend that practice nurses be employed by the HSE to increase efficiency and for the development of practice nursing. Currently GPs employ their own nurses to service both GMS and private patients. If practice nurses were employed by the HSE arrangements would need to be put in place to ensure the care of private patients.

Ref: Building a Better GP and Primary Care Service, Phil Ni Sheaghdha, Director of Industrial Relations, INMO, 14th July 2017

Comment:

It is evident that nurses want to be more involved in primary care and the success of the diabetes programme has allowed them to develop their interest in chronic disease care. They use the pharmacist to deal with medication queries and value their advice. It may well be that the pharmacist is more readily available than the GP and is a trusted source of advice especially with medications in diabetes care.

Additional training in mental health and wound care indicates areas of demand in their communities. Nurses are interested in joint training with other clinical staff, which has the added benefit of building networks for the benefit of patient care.

For public health nurses and the diabetes nurse, access to the GP and patient record is essential and can be facilitated by electronic developments.

3.6 Pharmacists

3.6.1 Doing pharmacy differently

Overall the two pharmacy representatives (Irish Pharmacy Union and Irish Pharmaceutical Society) who were interviewed reflected the findings from the research as a whole.

Pharmacists as a profession have outlined their approach to healthcare as follows:[68]

- Providing structured population health information and awareness campaigns and preventative medicine to support the maintenance and improvement of the health of the public;
- Providing expertise in assisting patients with their chronic diseases and medication and where appropriate, through supplementary prescribing in collaboration with the patient's GP
- Providing medication reviews for at-risk and vulnerable patients in the community and local settings e.g. nursing homes, in acute settings; and
- Reducing prescribing errors and optimising the impact of medicines for patients.

In the interviews, pharmacists were aware of the increased pressures and expectations on primary care and GPs in particular. They saw themselves being able to share some aspects of the chronic disease management care with GPs. Some already offer testing and monitoring services such as warfarin, blood pressure and cholesterol testing. They see the expansion of these services as easing the pressure on GPs.

They said pharmacies could also provide simple health screening services and supports to the public, which is current standard practice in a lot of pharmacies, e.g. tools to quit smoking. However they saw the need to have a clear process to refer more complex cases to GPs.

Currently there are no formalised communication procedures between pharmacists and GPs, or requirements for GPs to share information on disease conditions. Pharmacists said this would allow for easier transfer of information back and forth through an electronic system. They saw access to an electronic record as allowing them to update patient reactions to medication. The secure Healthmail system is now made available to pharmacists and will facilitate the confidential transfer of information.

Local level initiatives that currently take place on an ad-hoc basis, involving ongoing patient care meetings between pharmacists and GPs were also considered very positive from a pharmacist perspective, especially in terms of building a relationship.

Pharmacists would like to see reasons for medication being prescribed listed on the prescription, so they can substitute with appropriate alternatives or doses if necessary. They saw themselves as familiar with all the medications a patient is on. Exploring any opportunities for pharmacists to monitor and issue repeat prescriptions in certain cases, e.g. birth control, would be a positive initiative for patients.

Comment:

Community pharmacists play a significant role in medicines safety by double-checking with the prescribing GP especially about interactions. The system that has evolved in Ireland and elsewhere has largely separated off the prescriber from the dispenser. A minority of GPs dispenses medication in rural areas. The separation is to avoid conflicts of interest where the prescriber might, for example, be overly influenced by deals available on batches of drugs. It is similarly important where a patient should have some drugs withdrawn or discontinued that the dispenser does not have a vested interest. It is important that this separation continues, as retail pharmacy will want to avoid potential conflicts of interest. Continuing to provide safe medicines at a reasonable price will help pharmacists to maintain their high level of public trust.

3.6.2 Clinical pharmacy

In order to maximise the medication management skills of pharmacists particularly in chronic disease and avoid any perceived conflicts of interest, clinical pharmacy has been developed and welcomed by both GPs and pharmacists in the NHS[69]. Salaried clinical pharmacists work as part of the general practice team to resolve day-to-day medicine issues and consult with and treat patients directly. This includes providing extra help to manage long-term conditions, advice for those on multiple medications and better access to health checks. The number of clinical pharmacists has grown quickly in the NHS as they are seen as pivotal to improving the quality of care and ensuring patient safety[70].

Having a clinical pharmacist in general practice means GPs can focus their skills where they are most needed, for example on diagnosing and treating patients with complex conditions. This helps GPs manage the demands on their time.

3.7 The National Patient Forum Focus Group

A focus group with the members of the National Patient Forum was carried out by the HSE. Four key themes emerged, namely Quality, Access, Cost and Range. These quality services would include a structured system of communication with clinical specialities and diagnostic facilities in order to support GPs to manage patients, particularly those with chronic diseases, in the community.

The National Patient Forum sees access to these services with extended opening hours to include late openings during weekdays and opening on Saturdays. Patients would have access to 24/7 GP care and would include timely transfer of records from one GP to another and from primary to secondary care.

The National Patient Forum sees the cost of these services would be reviewed to include free at the point of access, funded through taxation or for a small fee. This review would need to de-commercialise primary care and standardise services and incorporate set prices.

Finally The National Patient Forum suggested the range of services would need to integrate with public health nurses, pharmacy and all other primary care specialists and services and the GP would need to be the team leader in the community; while in rural areas GPs need to be part of the community with GPs given incentives to engage in local communities.

In addition, the Forum stated that GPs should provide a service that allows bloods to be tested on site and that GPs should be mandated to be part of the primary care network. There should be a specialist GP in every practice who may have a clinical specialisation in geriatrics, paediatrics, rare diseases, etc.

Comment:

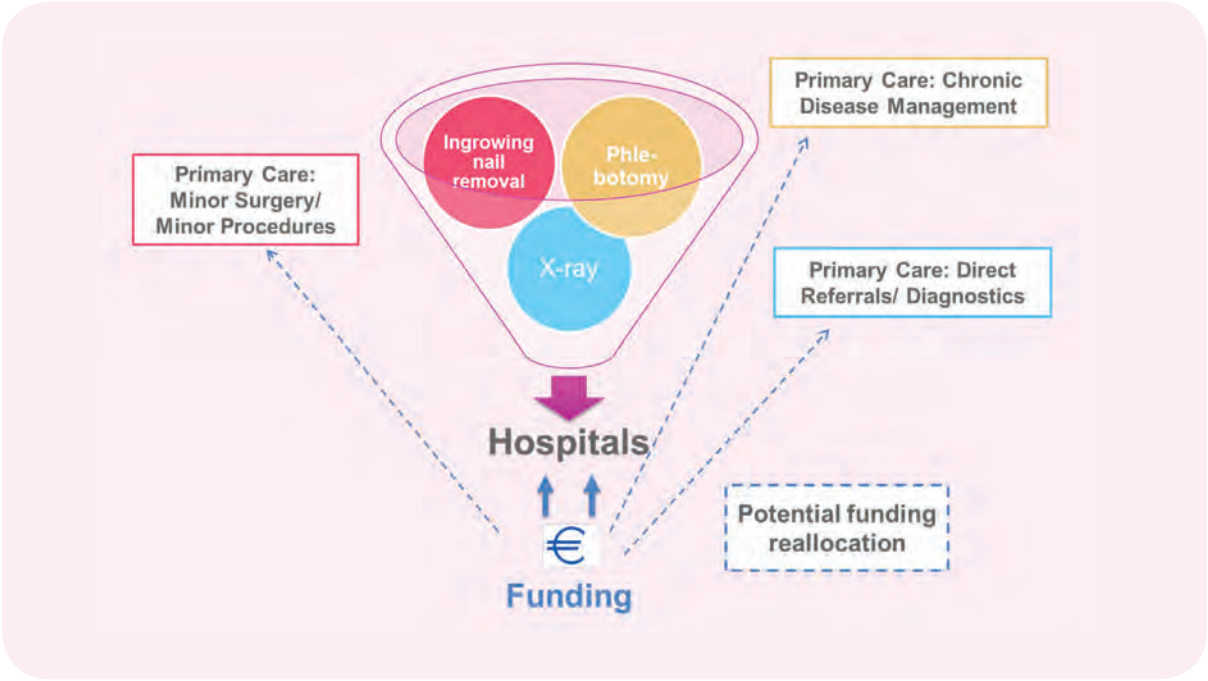
The Forum sets a challenging agenda for primary care and general practice. Some of the issues raised concern primary care and GPs also, such as better communication and availability of diagnostic facilities. The support of the Forum for GP led primary care is also examined in detail in this report.

Specialism and generalism in general practice is often debated. GPs with special interest were common in the NHS but have declined because the anticipated impact did not happen. Remaining a generalist is a challenge with healthcare systems having concerns about the future of the generalist[71].

3.8 Reallocation Of Selected Funds From Hospital To GP

Reallocation of funds

Source: GP Services Research - Service Users and Service Providers report; Coyne Research, January 2017



Opportunity to reallocate funds considered key by hospital consultants and GPs in order to address current situation

Both GPs and hospital consultants considered the reallocation of funds from hospital to general practice as a key development in addressing the problems in the current system. This included minor surgery and procedures, chronic disease management, and direct referrals. Direct access to diagnostics such as x-Rays and ultrasound were seen as priority areas for resources. It was frequently stated that too many patients were unnecessarily funneled into secondary care because of the weakness of primary care resources. This aggravated long waiting lists and queues in emergency departments. Having a fund for staffing, training, and equipment was seen as necessary. The perception of both GPs and consultants was that free access to GPs had increased over time. The more recent Financial Emergency Measures in the Public Interest (FEMPI) cuts in response to the financial crisis[72] were frequently mentioned. They were seen as responsible for doubts about the sustainability of general practice.

The majority of GPs felt that the current GMS contract should be more reflective of the time spent with patients. Geriatricians and psychiatrists value the time GPs currently spend with more complex patients. They also supported the remuneration of more time for complex cases.

3.9 Review Of Current Funding Structures

This was seen as ranging from a short to long-term task by both GPs and consultants. It largely confined itself to reviews of existing payments and allowances. They included the insurance industry as a longer-term project.

Short to long-term review of funding

Source: GP Services Research - Service Users and Service Providers report; Coyne Research, January 2017

- Current levels of funding are not considered sustainable for the increasing demand placed on GPs and their practices.
  - These funding issues were raised by both GPs and healthcare stakeholders.
- The key areas that are considered important to address are outlined below.

3.10 GPs In Training - Vision Of Their Future

A focus day was arranged bringing two Dublin-based GP training programmes together. The day was attended by 70 third and fourth year GP Trainees in addition to eight tutors all of whom are practising GPs, and who acted as facilitators.

The diagram on the following page shows three strong themes from our consultation with the GP Trainees. Their vision for a new way of delivering GP led primary care was threefold:

1 The building of a multidisciplinary team that includes the management of complex prescriptions and psychosocial issues. They were aware that the regular bread and butter illnesses needed to be looked after also, as not all of general practice is complex.

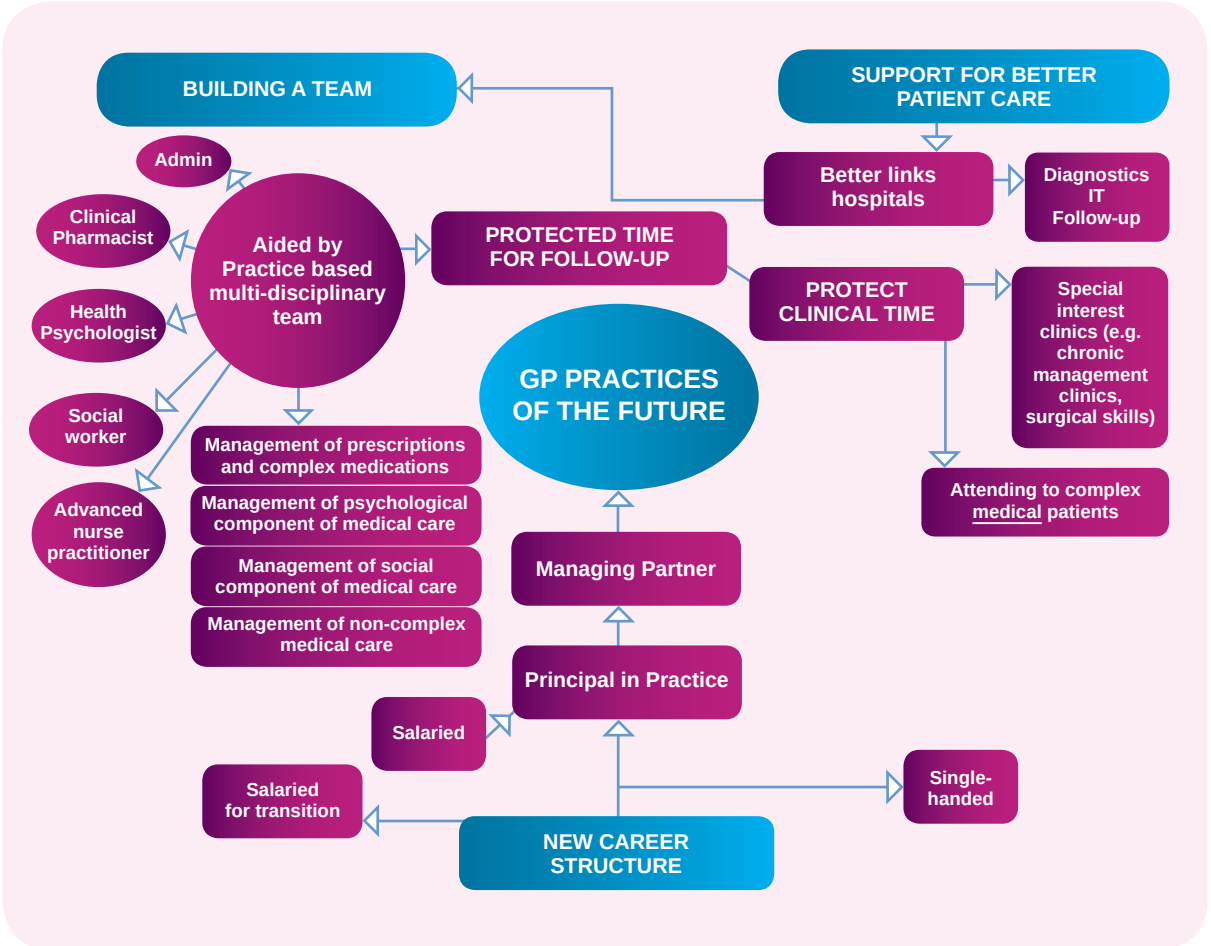
2 Supports for better patient care included access to radiology and better IT that linked with hospitals. They found poor access to diagnostics clinically frustrating and professionally dissatisfying. For them, having enough time was the real currency of general practice in order to make full use of their expensive training.

3 They want a career structure. They come from backgrounds of high professional achievement and being a GMS principal was not always seen as the desired career end point especially early on. Some were daunted by the complexity of practice management. A significant minority wants to start out in general practice on a salary, at least for a limited period of time. They saw the salary as grant aided from the HSE. They see themselves moving into partnership when they get to know the ropes including future colleagues. Later on they were willing to do their share of managing the practice as a managing partner, as in some law firms. None saw themselves in singlehanded practice.

The views of the GPs in training inevitably reflect their Dublin location but the themes of the exercise are likely to resonate with a wider group. It is likely that GPs in training in rural Ireland have additional concerns such as singlehanded working, viability of small lists and greater doubts about the future. REF https://sapc.ac.uk/conference/2016/abstract/no-doctor-no-village-ethnographic-study-of-advocacy-campaign-rural-general

GPs In Training - Vision For New General Practice

Source: O'Dowd T, Ivers J and Handy D. (Current Report)



Part 4

Plenary Session

As part of the iterative approach to this work the HSE convened a plenary session on the 24th May 2017. It included interested parties such as the GP representative bodies, the Irish College of General Practitioners (ICGP), practice nurses, allied health professionals, academic bodies, patient representative bodies and members of the public.

The purpose was to inform interested and committed people about the scope, nature, results and provisional conclusions of the research.

In his introduction, John Hennessy, National Director Primary Care, HSE, remarked that healthcare systems internationally have become unsustainable. In Ireland the system had been geared towards specialisms, with under-investment in primary care. This has now become an issue especially with our aging population. We have now arrived at a confluence of opportunity to redress the balance: our hospitals are straining at the seams, we have a recovering economy and the international evidence for primary care systems is hardening. In this context, this report has broadened from an information exercise for the new GP contract, to a wider look at the development of the primary care system. John Hennessy outlined the objectives of the plenary as being to take on board contributions for inclusion in the report, establish a road map for the future and ultimately achieve a more balanced health system.

Presentations

Tom O'Dowd, Trinity College Dublin presented some of the findings from this report, under the title 'Building Better Primary Care Services'. Alice Wainright, Coyne Research, presented a summary of stakeholder engagement findings. The full findings of the Coyne research are available on the HSE website.

The International Perspective

The International Perspective, 'General practice in Scotland - changing to meet the needs of patients and GPs' was presented by Dr Alan McDevitt, Chair of the Scottish General Practitioners' Committee at the British Medical Association.

Dr McDevitt outlined some of the problems facing the healthcare system in Scotland:

- A changing population;
- Inability of hospital beds to meet demand;
- Unaffordability of the current system; and
- GPs wanting independent contractor contracts.
  For GPs independence is the key. They want practice based rather than area-based lists. They want practice expenses, including staff costs, paid by the State. They see their data controller role as a risk.

Retention of GPs in the system has become of paramount importance. GPs need to be paid to deliver essential services, with funding directed at improved outcomes of care.

The plan in Scotland is to employ technicians to perform chronic disease reviews to free up GPs and nurses for treatment roles. There will be no loss of income for GPs giving up services.

With regard to funding, £63 million is the current spending on primary care, with one third more needed. In Scotland there will be an annual increase in the budget, to reach £250 million by 2021, with 50% going to primary care and the other 50% to general practice.

Other plans in the pipeline are:

- Services handover (eg vaccinations)
- New staff (flip staff from primary care to general practice)
- Stabilisation of current GP practices
- Cluster development of practices
- Professional time for development
- Transitional money to help implement changes
- Promotion of general practice to attract and retain GPs

Comment:

It was striking that Scottish GPs have developed a strong trust with their Health Department and a vision for the role of general practice and primary care in their health system. It was also noted that Scottish GPs now realise that general practice needs to be 'talked up' as negativity is having an impact on recruitment and retention.

4.1 Feedback from Plenary Discussion

Five key themes emerged from the plenary session, namely Resources/Funding; Challenges; Engaging Others; Political Support; and Difficulties facing young and aspiring GPs. Below is a selection of findings from each of these key themes.

Resources/Funding

Not surprisingly resources and funding emerged as a key theme. The need to go beyond current mechanisms and include innovative strategies were seen as necessary:

"..We need a very substantial transitional investment… in order to move from the overly hospital-centric system we have now towards a community primary care GP based system... we need, over the course of 10 years, to see an extra half billion a year invested transitionally…. I'd be arguing for an escalating investment, recognising that it takes time and you need to create a pipeline in order to develop the supply of health professionals and healthcare professionals that we need in order to build this type of service. So it has to be done smartly"

(Tony O'Brien, Director General of the HSE)

"…if you have blue sky thinking you have to have blue sky funding to back it up…"

(John Gilman Chair ICGP)

"we need to do things that go beyond, well beyond, the normal annual cycle and exploits to the greatest extent possible the fact that the current confidence and supply agreement commits to multi-year funding as opposed to single year funding, which doesn't provide an opportunity for real planning"

(Tony O'Brien, Director General of the HSE)

"I would say as well that much of our discussion on resources from year to year focuses on what additional we need just to maintain things at their current level. Perhaps the challenge is to shift the discussion away from saying 'Give us a half a billion just to keep doing what we're doing, the way we're doing it', to 'Give us a half a billion and we can look at different ways of leveraging that to do more in primary care and have, as John says, a more balanced health system.' So I mean I can't wave a wand and make it alright but I think we should see ourselves as being all on the one side rather than being in opposition to each other."

(Fergal Goodman, Primary Care Division, Department of Health)

" I guess I just want to say that we're really good, the HSE, the Department, GP organisations and GPs, at identifying all the things we can do. We're really bad at funding those and having a plan to bring them into place. So notwithstanding that the future healthcare committee is going to report, there is no guarantee that that's going to get through the Dáil, there's no guarantee in the budget for this year. And yes, we can talk up general practice but unless you offer people a sustainable funding model, and that is missing in every conversation that's ever had by general practice, the sustainable funding model is missing. And until that's addressed every single issue that was raised today requires funding, cultural change in itself requires funding."

(Susan Clyne, Irish Medical Organisation Chief Operating Officer)

Challenges

These centred on change, including information technology:

"Two challenges, really; one would be to get an alignment in terms of the broad direction we want to go in. I think we're moving quite well on that road. I see a lot of alignment in our respective agendas…..of course the obvious issue then is finding a resourcing capacity to enable what we want to do and what we agree is a priority".

(John Hennessy Panel Member and Director of Primary Care, HSE)

"…I suppose the challenge is that it does involve a lot of change for people. Potentially if we're going to deliver that into primary care, if we're going to move a lot of work that's currently happening in hospitals into a primary care setting, if we're going to change the relationship between the hospitals and the primary care and the GPs. It involves a lot of uncomfortable change for some people.…But how to get people to move. I suppose it's a big challenge..."

(Dr David Hanlon, Panel Member, GP and Clinical Advisor to the HSE)

"We've got a very clear plan as to the sort of things we want to deliver and we've shared them with GPs in whatever forums we have been able to do so. We work very closely with the Irish College of GPs through the GPIT group and I think it's a very good collaborative working group between the HSE, the Department of Health and the college and interested GPs, or GPs with a special interest in IT. In terms of what we're doing to develop the IT systems across the service to link other parts of the service, I think there are different challenges depending on which part of the service we need to connect with. There's always challenges in relation to our linkages through to the Secondary Care sector. I suppose I'd echo Ronan Fawsitt's comments and observations in relation to connectivity with the hospitals that really the clinical connectivity on a professional basis is number one and the technology should always roll in behind that. I don't think putting in technical solutions without working on those relationships in parallel actually makes a huge difference."

(Niall Sinnott, IT Delivery Director for Primary Care within the Office of the Chief Information Officer, HSE)

Engaging others including hospitals and allied health professionals

The need to engage missing partners, specifically secondary care and Allied Health Professionals to support GP led primary care emerged as a key theme:

"…But what was breathtakingly missing from this morning was a vision on how we engage with secondary care. Secondary care has become hospital centric and hospital centric care has failed, that's why we're all in this room. What we mustn't do is create another silo within primary care or within general practice that doesn't engage properly with secondary care. Because if we're going to shift the care from the hospitals into the community we're going to have to do it by agreement..."

(Dr Ronan Fawsitt, GP)

"..One of the things that strikes me today, I suppose, is that when we hear the discussion about the GP led version I'm also interested in the perspectives about what practice nurses can do, pharmacists, allied health professionals and so on. There are an awful lot of moving parts here but I would like to give you an assurance that when it comes to seeking additional resources we are in there…"

(Fergal Goodman, Primary Care Division, Department of Health)

" ... there's an OECD report that puts Ireland ... second from the top of funding on health services. ..... Denmark was getting 4.7 funding of the health budget to GP services. Now Ireland is getting ..... a little over 4% of the health budget to GP services. And I'm just wondering, the Danish health service is quite good, I'm just wondering, ... why is it, with our four point something percent, I think it might be up to 4.5, and Denmark is 4.7, and they have a good health service, we're almost funded nearly as high Denmark ...."

(GP Participant)

"Denmark has the reputation of having cutting edge primary care. But when you look at their allied health professionals they seem to have a greater range of allied health professionals than some other countries. So it seems that they have made some progress in GPs doing what they're good at and others like counsellors, psychologists, podiatrists, all that kind of area being involved and doing what they're good at as well .... So it seems to be that they used their allied health professionals in, I suppose, a more open way than we would here. And it goes back to the kind of thing that John says, the kinds of supports that surround the GPs makes a difference as well."

(Tom O'Dowd, GP and Panel Member)

Political support seen as vital

Participants noted the need for political will to ensure the success of GP led primary care:

"The political support is coming. There's no doubt that without primary care without general practice leading that the future of the health service is in dire straits…"

(Dr Ronan Fawsitt, GP)

"…we're very good at coming up with the solutions, but if you don't have the body politic moving with you in the same direction nothing changes…"

(Dr Emmet Kerin, NAGP President)

"To me the biggest challenge is whether or not there actually is true government commitment to actually funding this change".

(Dr Nuala O'Connor, Panel Member, ICGP)

The difficulties facing young and aspiring GPs

"I appreciate fully that it's often difficult for young clinicians to make life determining decisions when there isn't huge certainty in the reimbursement profile so I'd hope we'd be able to do something and work on that…….. the GP trainees in terms of what's important for them and what would make it attractive for them to stay in Ireland. I think they need certainty and they need confidence that there is a programme over an extended period of time going to be in place to provide that."

(John Hennessy Panel Member and Director of Primary Care, HSE)

"..unless we make general practice an attractive profession, unless we make the supports in there, and I have to hasten from the feedback that I get from GPs, this isn't at all about money, it's more to do about making sustainable careers and living for GPs, particularly in challenging areas such as rural areas and in inner city"

(Brian Murphy, Head of Planning, Performance and Programme Management, Primary Care Division, HSE)

"The bottom line is that they have middle income aspirations and if they don't see those aspirations folding out they will leave, they won't take up very hard working positions in practices".

(Dr Brendan O'Shea, ICGP and GP in Kildare)

"... a common theme that I hear from our members is their frustration at dealing with a dysfunctional hospital system. They're fearful that any proposed change in the health system will just replicate the current feelings in secondary care and translate this into primary care so that the problem is shifted from secondary care to primary care."

(John Gillman, Chairman of the ICGP)

"Every new initiative has required GPs to make additional investment, both in IT, in their own personal and professional time, in human resources, and they have been left burnt, badly burnt. ..... The capacity simply isn't there to provide the service we are providing now. And finally, Dr McDevitt made, why are we the last resort for everything that fails within the Health Service? At 5 o'clock you get a message from a social worker, from a nurse, from someone, there's a crisis. A lab rings you, puts it onto your phone or messages you with a lab result that you have to deal with. .... And so young GPs are choosing, just like they are in Scotland, not to go in. So you haven't filled your training places this year, young GPs would like to be GPs, they'd like to have security. But they're looking at a generation of GPs who have been badly, badly burnt by this State."

(GP Participant)

4.2 Written Feedback from Plenary

All participants were given the opportunity to submit written feedback from the plenary at the close of session.

Key themes emerging from analysis of feedback were lack of consultation with wider primary care professionals and resources/investment.

'Lack of consultation with wider primary care professionals'

Participants noted a lack of consultation with the wider primary care team suggesting that the report focused mostly on GPs and general practice:

"Very disappointed today was all about GP and not wider primary care team."

(Claire Donnelly - Physio Manager)

"… only 2 practice nurses, both from the same surgery were involved in the discussion prior to today as part of the research presented (draft report). I am delighted that the IPNA (Irish Practice Nurses Association) was invited here today but I am wondering how you get a good representation of practice nurses by not contacting the IPNA prior to today's meeting?"

(Karen Canning - IPNA Chair)

"The session focused on the challenge facing PC[73]. However we did not sufficiently explore nor did it have presentation or representation from the AHP [allied health professions] that could provide solutions to these problems. As ever, doctors are seen as the only solution to our healthcare problems. There needed to be greater input by AHPs"

(Helen Barry, Academy of Clinical Science and Laboratory Medicine)

'Resources/investment'

The need to invest in resources to build capacity emerged as a key theme in written submissions:

"…resourcing of AHPs in primary care need to take place with resourcing GP Practices, e.g. Dieticians (Currently between 0.2-2 per 50,000)…This will enable delegation of tasks and reduce burden on GPs. Also important is the resourcing of admin. Currently, AHPs in the HSE are spending 20-30% on admin tasks that could be delegated".

(Mairead Aherne, Dietician Manager)

"I was disappointed that the expertise of the PN [practice nurse] was not acknowledged. In long term illness management this is essential and requires funding and development. I would agree with Dr O'Shea and the need for a structured career process "career path" for practice nurses, it may enhance capacity. Competency development is essential to support any GP contract"

(Anonymous)

In addition to the key themes that emerged a patient advocate shared an experience, which highlights the need to engage key stakeholders and build capacity for better primary care:

"OK, my name is Cara Madden, I'm from Patients for Patient Safety Ireland. And I'm coming from a patient's point of view. Mental health with GPs is very, very small. They have no direction, they don't know where to go, who to go contact, when they have to refer somebody over. I think it's an absolute disgrace that the HSE haven't got that referral model in for this because of our young people that are out there dying, after what's happening in Galway and as a mother myself of a person with mental health. You're the first port of call, our GPs. You'll always be our first to call because you're the people we trust. So please, for God's Sake, try and get something done here, we need it as well. Thank you"

(Cara Madden Patients for Patient Safety Ireland)

Part 5

Discussion and Conclusions

5.1 Discussion

The evidence supports a decisive shift to GP led primary care, which is central to transformation of the health service as a whole. There is an unusual consensus in Ireland at political level, among policy makers and practitioners that this is the way to go. It still won't be easy. A move to primary care is a philosophical, political and financial journey that challenges a society impatient for better health services. It also challenges a political system that is attracted to having more hospital specialists while ignoring the need for and value provided by generalists. They supply the bulk of trusted medical care for local communities.

There are opportunities for quick wins. Providing additional staff such as practice nurses, increasing mental healthcare and investing in IT will provide such wins. But to turn our healthcare system into a modern, responsive and equitable endeavor will take a decade or more. Significant ongoing resources, new thinking and leadership will be essential if the decisive shift to GP led primary care is to be given a chance. It does mean asking committed hospital colleagues to come to terms with the fact that their system needs to be reformed and that primary care has a significant role in such reform. For us in Ireland the upcoming negotiations on the new GP contract represent an opportunity to begin the journey of reform.

Reform of primary care has been on the agenda for several years. This reflects an acknowledgement that the current system is fragmented, poorly developed, and unfair. There is an expectation that a reformed system will contribute to wider health goals[74]. The underinvestment in the infrastructure of the health system is recognised within and without the system[75]. There is a consensus that primary care needs to be strengthened at international and national levels. Where this has happened improvements have been seen surprisingly quickly, especially in the US where hospital costs were out of control. The traditional model of hospital dominated care is becoming unaffordable and indeed inappropriate for modern societies. Specialist hospital care commands significantly more resources and personnel than generalist care in the community. This is evident in Ireland from the proportion of the health budget devoted to general practice at 4.5%. In the 33 years of collection of data on the structure of general practice the number of GPs has grown by 61%[8]. From analysis of the Comhairle na nOspideal data the number of public consultant posts has increased by 153% over the 38 years to 2013[76,77].

Starfield cautioned that an imbalance between generalist and specialist practitioners led to an imbalanced and ineffective system that did not maximise health or spending[2,78]. There is an approximate balance nowadays between the numbers of public consultants and GPs in our system.

Repeated surveys have shown a sustained level of trust in general practice by patients. In the United States they have used trust in the family physician to introduce other appropriate members of the primary care team to the patient. GPs in Ireland can also use their enormous trust to introduce appropriate additional staff to patients to extend relevant care to patients.

There are significant professional differences between GPs and primary care staff, in terms of approaches to problem solving and training, that have to be overcome to make primary care work. There are not yet enough centres where primary care teams work well together and that can become role models for the future. There are other players in the area such as pharmacists and allied health professionals who see themselves making a contribution – often of a specialised nature[12]. There is always the risk of turf wars breaking out between professional groups that will set primary care back. Rounded leadership from all the professional groups focused on patient care is the model to be encouraged and developed by universities, training programmes and funders.

GPs say that poor access to diagnostics limits their capacity in making advanced diagnoses and in keeping patients at home. They say that their clinical skills are disrespected in favour of junior hospital doctors who have preferential access to such tests. GPs in training report considering a career change based on such restrictions to their practice of medicine in the community.

Younger doctors report wariness about entering the current GMS contract on foot of experience and advice from their GP tutors while in training. This has led to an unspecified number of younger GPs taking what is 10 years of expensive training abroad for the benefit of another system. It is always good to have GPs with experience of another health system but the fear is that they will stay away. The GPs in training who took part in the research for this report saw themselves working in Ireland in general practice. They looked forward to a revamped system that will include larger teams and better opportunities to use their hard won clinical skills.

Long term conditions

Like many things in medicine when it comes to chronic disease management the evidence is not as clear as many advocates would like, especially for multiple chronic illnesses[79]. The guidelines are criticised by GPs as being overly hospital dominated and not sufficiently focused on the patient [80, 81]. Such diseases are now being called 'long-term conditions', which is a term that gives a more rounded view of what is going on.

Single chronic diseases are easier to manage but most patients over 60 have two or more chronic illnesses. There are many single disease guidelines in use, which were originally expected to improve care and reduce hospital attendances including admission. It has been argued that evidence based guidelines are inappropriate for people with multiple conditions, resulting in overtreatment and overly complex regimes of assessment and surveillance[80]. However there is little to replace them with, and evidence based guidelines have contributed to improved care by providing clear standards against which care can be assessed. Doctors increasingly feel unable to deviate from them, as this might be assessed as substandard care, or lay the doctor open to criticism or sanction[81].

There is recent evidence from a large UK GP study of over 230,000 patients showing that the effective component in managing long-term conditions is continuity of care. This means seeing the same doctor on most occasions. Patients with low GP continuity of care saw various general practitioners in their practice more often, thus generating higher workload. Those patients who saw the same GP in their practice on 8 out of 10 occasions had 12.5% fewer hospital admissions than those who saw the same GP on 3 out of 10 occasions. Patients in this study were aged between 62 and 82 years. All had commonly occurring conditions that were manageable in general practice. Smaller practices were more responsive in managing long-term conditions[82].

Chronic disease management can all too easily become process driven in response to simple fee structures. It can ignore the value patients place on the ongoing relationship they have with their GP, which is called continuity of care in the medical literature. A study in Glasgow of longer consultations with the same GP showed improved patient well being. Support for the GP was also considered an important part of the success of the programme[83].

The 'secret sauce' in the management of long-term conditions is patients receiving ongoing, good quality clinical care from a trusted doctor. In Ireland continuity of care is much prized by patients and is provided by GPs and is one of the strengths of our system. Looking after complex patients requires additional time which has a monetary value in terms of reducing hospital admissions[82]. Any weakening of continuity of care means more hospital admissions where costs are difficult to control. Anything that can be done to enhance continuity of care by GPs is time and money well spent. This requires resourcing the GP team so that chronically ill patients with long-term conditions who need to see the same GP frequently are seen in a planned manner. It also requires the GP practice to cater for continuity of care by reducing short-term locums, plus staff training and providing home visits when appropriate. This is a big commitment that requires resources.

Patients below the radar

The State is the major purchaser of care from GPs and the current contract has led to a 'one-size fits all' approach, which has caused frustration for both parties. GPs may forget their frustrations are shared by the State. These frustrations can prevent alliances being formed to shape a joint vision and to advocate together for better resources. In the UK the Royal College of General Practitioners has developed a 'critical friend' relationship with their own Secretary of State/ Minister for Health and chief officers in the NHS. They have joined them in a bid to increase the proportion of the entire health budget for general practice to 11%. Some recent UK surveys report GPs getting back in control of their workload, focusing on patient care and having improved work satisfaction. Investment in IT, one of their priorities, is transforming the use of information for the betterment of patient care[84].

The financial and indeed professional dependence of Irish GPs on one main purchaser needs to be part of a strategic review by the representative bodies. Such dependence has a number of knock-on effects. It has led to a single focus for industrial relations with little or no attention being paid to the development of private practice and in particular the 'squeezed middle' without medical cards[19]. They need cost effective care that keeps them from waiting for expensive hospitals and clinics in either the public or private sectors. The data in this report suggest that there is significant room for GP development of care for the majority of patients who are not covered by the State. Private patients are low consulters – perhaps too low. When they attend they are likely to bring a list of clinical problems, which is a reflection of need and a desire to get value from the consultation. How many attend hospital specialists for conditions that can be dealt with more appropriately by their GP is not known.

Minimum Benefit Regulations, made under the Health Insurance Acts[85], require insurers to offer a minimum benefit to every insured person. GP cover is not included as a minimum benefit in these Regulations. Some health insurance plans cover elements of GP care such as limited GP visits and elective procedures carried out in a GP surgery. However there are no insurance products available to cover, for example, chronic disease management. Indeed some insurance plans may encourage the patient to take a more expensive hospital option than attending their GP for chronic illness.

In other countries well-developed private health insurance packages include general practice as part of the healthcare system. It reduces the reliance on a single payer, introduces competition and gives negotiating power to doctors.

The health insurer interviewed for this report viewed working with GPs as important for private patients as the absence of developed primary care oriented packages deprives them of system based care, especially for long-term illnesses. The development of GP health insurance in Ireland would reduce the dependence on individual fees and allow a parallel system of care to develop for the approximately 60% of patients not in any primary care system. A recent consultation process on health insurance was inconclusive with insurers showing little appetite for entry into general practice other than simple procedures[86].

Other options need to be examined by GPs themselves. Primary care medical insurance has grown significantly in the US from the long standing physician established Molina insurance[87]. This insurance scheme was founded by family physicians with the values of primary care at their core. GPs and their Co-ops provide medical and urgent care, that are healthcare packages of need and value to their patients. Such packages require the promotion of the ICGP and the representative bodies at national levels.

Regular contract review

The US experience with family physician contracts is that they need ongoing and regular review especially if incentives are built in to the contract. Over time some incentives need to be replaced with others. The current Irish GP contract is widely seen as in need of change. The Quality Outcome Framework (QOF) system in the NHS shows that an over reliance on incentives distorts the system away from immediate to chronic care. This has resulted in same day appointments becoming almost impossible in many UK practices. There are large ongoing pay-for-performance programmes in the US and UK which will be reported on in due course. In an opinion informed by a guarded report from the Health Foundation[33] Dr Jonathan Steele (PwC) says that approximately 7% of the GP budget should be incentivised as the 15% level in the QOF system led to a distorted system[34].

Data and its uses

Internationally the current healthcare system has been described as over-regulated and over-inspected and needs to develop a partnership with managers if it is to be responsive[88]. This means that data produced in GP led primary care needs to be jointly used with management to make a case to the political system for enough resources to succeed.

The Health Research Board (HRB) sees health data as a valuable national asset[89]. It points out that Ireland has many data resources that could be used to enhance health service delivery and inform policy and planning. The use of such data in a safe, secure manner, protecting privacy and confidentiality, is very important.

The HRB observes that many questions that could inform policy and practice are not attempted, or are abandoned or are delayed because data cannot be accessed in a timely manner[89].

There are good examples of the use of data in the NHS involving health and social services:

1. NHS England has an open prescribing website to promote safer prescribing. Every month, it publishes anonymised data about the drugs prescribed and each GP can run their own analysis[90].
2. QRESEARCH is a large consolidated database derived from the pseudonymised health records of over 24 million patients from approximately 1500 general practices using the EMIS clinical computer system. It is linked to hospital data and is used for research and practices are incentivised to code patient morbidity or illness. It has carried out relevant clinical research on fractures, diabetes and cancer[91]
3. The Leeds Health Record[92] allows health and social care professionals access to patients' up to date records of allergies, diagnoses and hospital letters including mental health.

Information technology

The electronic medical record (EMR) is central to IT systems that 'talk' to each other. It facilitates the sharing of information among physicians, patients, laboratories and diagnostic centres. All are agreed that it needs development in Ireland where people have become very 'tech savvy'. People are often amazed at the ongoing reliance on the fax machine in modern healthcare.

Patients in Israel have an IT system that can bring together information from hospital and community settings. The system enables patients to use the internet to access their personal health records, check lab results, schedule appointments, confer with a pediatrician online after regular working hours. Innovative applications in Maccabi include those in which patients can enter data from home. They include decision support tools and tele-consultation between specialists in urban centres and patients and their family physicians in the rural areas. A virtual community has developed through which Maccabi's senior management gets ongoing input from a representative sample of its members. This system has been implemented in a system comprising largely independent physicians.

There is an increasing interest in telemedicine especially among the younger demographic. Experience in the UK shows it to be driven by private health insurers who permit a designated number of online consultations. An Irish insurer offers some GP telemedicine. The Scottish experience shows it to be a niche interest so far[93].

Information technology is also the basis for the continuity of care that is needed to monitor chronic illness with links to the relevant hospital specialty. Irish GPs are keen to get involved in chronic disease management. This is an area in which the GP infrastructure is present but not yet mandated or resourced. Call and recall is a major shift for a system that has traditionally reacted to acute illness. It means having an updated patient register with a facility to issue reminders to attend the practice for additional checks. Such checks will inevitably need action in terms of repeated blood tests, medication reviews and referral to other members of the team or to hospital. This additional work has the potential to overwhelm the current work of general practice unless it is carefully managed in the practices with additional nursing and medical staffing.

Will GPs be able to cope with additional work?

This is the most commonly asked question when the extended role of the GP is discussed. General practice is the one part of our complex health services that has not buckled under workload increases. Patient feedback for this study validates the important and trusted role of the GP as it is. Patients in the surveys had remarkably few ideas for the development of general practice. The National Patient Forum wants to take general practice down a more specialist role, which will dilute its generalist nature.

Training for medicine and general practice is a lengthy process and adjusting supply to meet demand in a timely manner poses difficulties. Increasing training places will enable supply to meet demand only after several years. Further increasing the number of GP places would also require increases in funding for medical education. Alternative approaches outlined in a recent 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[94].

Time is the real currency of general practice. It is comparatively expensive and in short supply. As a result it has to be managed carefully. If there is another professional in the team who can do a task competently and safely the GP can be freed up to do more complex work.

The GP role is strongest when it focuses on:

1. the diagnosis and management of undifferentiated illness
2. the management of long term conditions which include frail patients
3. clinical and practice leadership
4. needs assessment to provide relevant services for patients

However without evidence of what goes on daily it is difficult to predict and plan for a future where general practice and primary care will inevitably play a greater part in the health services. There is much published on physician perceptions of rapidly rising demand and unsustainable workload. Good data about workload activity are essential to develop the primary care service. Such data will only help to place resources where they are needed.

5.2 Conclusions

International comparisons

1 Primary care that involves the GP adds trust, value and understanding to the system.

2 International evidence shows that primary care improves health outcomes at lower costs[2, 5].

Funding and staffing

3 For general practice and primary care to develop there are once off costs, short-term costs and longer-term costs. A transitional funding arrangement will be needed to develop additional accommodation, IT, upskilling of staff and ongoing services.

4 There is consensus about GP led primary care in Ireland. It is not in place and for it to happen will need management resources and accommodation at practice level. There is a range of possible involvements from attending primary care team meetings to managing a devolved budget to include staffing.

5 If GP led primary care extends to budgetary involvement it will need a governance system to be developed for overall direction and for accountability for resources. If GP led primary care is to play its part in the coordination of care between hospital and GP, significant IT investment needs to be made. GP led primary care in underfunded systems that have been reoriented has led to significant changes within 2 years (Vermont[5] and North Carolina[66])

6 The proportion of GDP spent on health in Ireland is up there with other developed nations. The proportion of the overall healthcare budget spent on general practice at 4.5% is low by international standards and needs to increase.

7 There is a significant difference between the amount spent on GMS patients and the amount spent by private patients in general practice. There is national and international evidence that doctors' fees discourage a significant proportion of patients from seeing the doctor when they are ill. The extent of the reliance on direct fees in Irish general practice is increasingly at odds with international healthcare funding. The international trend is for a system of care rather than the episodic care that can occur with out of pocket payments. There is a need for a system to be designed and built that can deliver modern proactive medical care to patients ineligible for GMS benefits.

8 The more complicated the reimbursement system the higher the costs. This is a feature of primary care internationally, which detracts from patient care in terms of time and money[15].

9 By international standards Ireland has well trained GPs that provide continuity of medical care, which is much valued by patients. Quick wins in developing GP led primary care can be achieved with additional support staff, which leads to additional relevant services for patients[5], [66]. However, GPs as small businesses are fearful of the risks of being employers. Secondment to practices from other agencies is a way to reduce this risk.

Diagnostics - radiology

10 Primary medical care that functions well internationally has appropriate access to diagnostics such as x-Rays, ultrasound and MRI. This is not the case in Ireland and GPs find it frustrating to have to refer patients into the hospital system when they could manage the patient in general practice.

Data usage and IT

11 Some countries are exploring IT at sophisticated levels to interact with patients and hospitals. GPs in Ireland have invested heavily in practice based IT. Transitional funding needs to be put in place for IT and data management. This will help the design of a financial system that rewards innovation.

12 General practice is a rich source of data that is poorly used. An agreed method needs to be found by GPs and management to use the data for better planning and financing. This requires a data management unit with a representative number of practices resourced to supply anonymised data.

13 Some GPs want to send electronic prescriptions to pharmacists, which is now possible with the secure clinical Healthmail system in place for GPs and pharmacists. There is uncertainty regarding the legality of such a practice. A code of practice does not exist between both professional groupings and needs to be developed. The development of clinical pharmacy within practices is showing considerable promise in the NHS especially where patients are on several medications.

Current contract and workforce

14 The current GP contract with the State has become inflexible and it is a source of frustration to both GPs and management.

15 Workforce analysis shows that in general, countries that have more GPs/10,000 population, do better. But not always — The Netherlands and Denmark have only slightly more GPs than Ireland — access to diagnostics, ancillary staff, good IT and governance that supports GP led primary care are equally important.

16 A private health insurer reported interest in playing a part in general practice but says it requires legislative changes. It is essential for the design and operation of a system of proactive medical care that a system is developed to develop a robust general practice and urgent care based product for patients who are not eligible for GMS benefits.

17 There is a good level of interest among GP Registrars (GP Trainees) in becoming salaried, at least early in their careers. This can be done directly with the HSE or by grant aid to the practices.

Long term illness

18 The evidence for the management of chronic disease is better for single diseases than for patients with multiple diseases. However there is growing evidence that continuity of care for long term conditions reduces hospital admissions[59].

19 Strategies that improve continuity of care in practices helps GP workload, improves quality of care and reduces the trauma and cost of hospital admissions. This is an area that requires joint cooperation between funders and GPs.

20 Pharmacists have argued for involvement in the management of chronic illness especially in the medications area. This will require significant cooperation between the representative bodies and between GPs and pharmacists at local level. Healthmail will facilitate this development but reassurance on any regulatory and data protection issues is needed.

21 The development of clinical pharmacy within the practice is growing in the NHS and helps GPs to manage their time. Such pharmacists are involved in chronic illness and drug safety and can implement deprescribing especially for the elderly on multiple medications[95].

Patient and key informant feedback

22 Patient satisfaction with their GPs in Ireland is high. Continuity of personal care is the key to this satisfaction.

23 Ease of access was highly rated with parents of young children being given priority.

24 Quality of communication with the GP was also rated highly.

25 Practice nurses were universally rated highly by patients.

26 Patients support more mental health services followed by x-ray diagnostics in general practice.

27 Both GPs and hospital consultants support the reallocation of funds from hospitals to primary care, to address chronic disease management, minor surgery and procedures in the community and direct referrals/diagnostics.

GPs in training feedback

28 GPs in training are energised at the thought of a new contract to allow a new way of doing things.

a. They want a new career structure to give them choice, especially early on in their careers.

b. A significant minority wants to be salaried either for a limited period or longer.

c. They support the idea of a managing partner, as in some law firms.

29 GPs in training have a clear idea of working in a team with other professionals for patient care.

30 Ireland is the place of choice to work for GPs in training, but the current system is not professionally satisfying for them. It leads some to consider returning to the hospital sector or leaving the system.

5.3 The Challenge: To Connect The Pieces

Many of the pieces of a good primary care system are in place in Ireland. These include a well-trained GP workforce, modernised premises, an active Irish College of General Practitioners and a referral system that works. All doctors are registered and indemnified. GPs participate in continuing medical education and audits for ongoing registration with the Medical Council. While the pieces may be in place, they are not connected in a manner that exploits the adaptability and the entrepreneurial nature of general practice to allow them to respond to current challenges. This includes a transitional fund for IT, a data support unit, premises and staffing to ensure its success.

The next phase of developing primary care is for the professional leadership in the primary care disciplines to come together with the HSE to develop a plan for the future. This will help strengthen primary care in Ireland to international standards.

Part 6

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