



**An Roinn Caiteachais  
Phoiblí agus Athchóirithe**  
Department of Public  
Expenditure and Reform

## **Spending Review 2018**

### **Government Expenditure on General Practice**

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The logo for the Irish Government Economic & Evaluation Service (IGEES), consisting of the letters 'IGEES' in a bold, white, sans-serif font inside a blue square with a white border.

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## Abstract

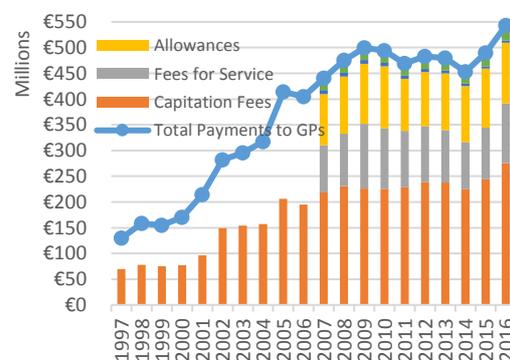
This paper aims to consider the efficiency and level of Government expenditure on General Practice in Ireland. Total current health expenditure going to medical practices in Ireland in 2016 was just short of €1,000 million. This excludes an unknown figure for total non-health expenditure on General Practice. Government expenditure on General Practice exceeds €640 million. Primary Care Reimbursement Service (PCRS) payments to General Practitioners at €543 million in 2016 account for the bulk of this. The remaining €100 million comes from a myriad of different funding channels which may or may not be considered primary care or health expenditure. The range of expenditure lines has the potential to obscure the full extent of spending and raises the possibility that the different schemes are compromising each other's effectiveness given their different objectives.

Addressing crowding out, along with more appropriate prescribing, improved assignment of GP time and greater use of practice nurses for triage and routine activities as well as other practice support staff (in combination with increased practice sizes) are areas that could yield benefits in terms of efficiency improvements and potential savings. In conclusion, evidence on the overall efficiency of Irish Primary Care and General Practice in Ireland is lacking and, in the first instance, necessitates a clear statement of the goals of the various components of expenditure and weighting these goals within a defined overall objective.

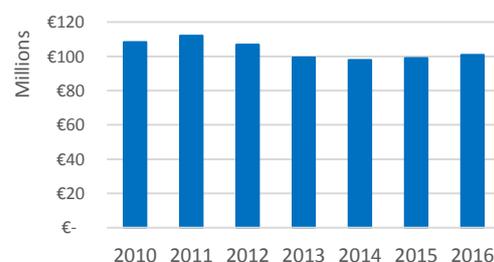
### Key Points

- The Primary Care Reimbursement Service made payments of €543 million to General Practitioners in 2016.
- An additional €100+ million in Government expenditure (broadly considered) is spent on General Practice through a myriad of funding channels.
- There are a number of areas that could yield benefits in terms of potential efficiency improvements and savings.
- Evidence on the overall efficiency of Irish Primary Care and General Practice in Ireland is lacking and requires a clear statement of the goals of expenditure.

PCRS: Total Payments to GPs



Estimated non-PCRS General Practice Gov. Expenditure



## Introduction

*“The purpose of a spending review is to increase the fiscal space available to Government for new, higher priority policies. This is achieved by systematically examining the scope for savings within baseline expenditure using available evidence and data and consequently by identifying spending programmes that are inefficient or ineffective in addressing priority economic or social goals. This approach counters the increasing tendency to focus only on incremental improvements in expenditure as part of the budgetary process.”*

*(Howlin & Kennedy, 2016)*

Given the above function of a spending review, this paper aims to consider the efficiency and level of Government expenditure on General Practice in Ireland. Developments in public and private health expenditure on General Practitioner (GP) services in recent years are explored. Then Government expenditure, broadly defined, on General Practice is examined in greater detail. As will be shown, there are a range of public expenditures and supports for General Practice in Ireland. Not all of these are strictly within what would be considered core primary care services. As such, an underlying question is ‘what is/are the key purpose(s) the state engages GPs for’ and are these prioritised appropriately?

The interaction of General Practice with other forms of expenditure is discussed before particular consideration is given to the efficiency of Government expenditure on General Practice. Examples of areas where efficiencies and savings in General Practice could potentially be achieved are outlined. Finally some conclusions and potential next steps are set out.

## Context

The health service in Ireland is a complex system. As part of this system, General Practice has strong interactions with other parts of the primary care system in particular, as well as with the secondary and tertiary care systems. This paper attempts to cover the main elements of those interactions including the role General Practice has on pharmaceutical, acute hospital and social welfare expenditures.

In terms of the policy context, public provision of Universal GP Care has been envisioned by a range of Government Reports from Primary Care: A New Direction (Department of Health, 2001) through to Future Health (Department of Health, 2012) and the recent Sláintecare Report. Also relevant are the planned renegotiation of the General Practitioner (GP) contract and the ongoing focus on shifting healthcare towards Primary Care.

### **Understanding Expenditure on General Practice**

- Total expenditure on General Practice is not equal to total General Practice income as GPs will have other sources of income.
- Total expenditure on General Practice can be subcategorised into public (government) and private expenditure, current and capital (insignificant relative to current) expenditure, health and non-health expenditures, and primary care (a sub-category of health expenditures) and other.
- Note that General Practitioners are independent private contractors and, as such, Government expenditure on General Practice is not equivalent to Government expenditure on directly employed health staff. There are costs of providing the state contracted General Practice service that GPs must cover (e.g. input costs such as equipment and materials, property, staff employed etc.).
- Not all Government expenditure on General Practice is for (core) primary care services. The range of spending covers core primary care services (primarily the GMS), specific public health initiatives delivered via GPs (e.g. other PCRS GP payments and the Maternity and Infant Scheme etc.), medical certification and so on.
- Some general items of Government health expenditure are difficult to apportion. Where spending relates to doctors as a whole, a judgement must be made as to the proportion attributable to doctors in General Practice. Similarly, where spending relates to the education of GPs, part of that training takes the form of paid placement in acute hospitals and could be attributed to spending on General Practice or Hospitals.

### **Overall Spending on General Practice**

It is important to consider the full extent of expenditure on General Practice from all sources not just because the service General Practice provides will depend on the totality of private and public funding but also because increases in expenditure on GPs through one channel will likely cause increases (or potentially decreases) in expenditure through other channels.

The Central Statistics Office (CSO) System of Health Accounts (SHA) provides information on the level of current health expenditure on medical practices. This medical practices category can be taken as representative of General Medical Practices despite the presence of a small number of medical practices that are not specifically 'General Medical Practices' (CSO, 2015). According to the most recent CSO SHA data overall public and private gross current health expenditure going to medical practices in Ireland in 2016 was just short of €1,000 million. Some €590 million of this was direct Government expenditure. A further €350 million was paid by households out-of-pocket and €60m was paid by health insurers to medical practices.

## Current Expenditure on Health – (General) Medical Practices - Ireland

Financing scheme	€m	€m	€m	€m	€m	€m
	2011	2012	2013	2014	2015	2016
Government/compulsory schemes	552 (63%)	578 (64%)	520 (59%)	492 (56%)	549 (58%)	586 (59%)
Voluntary health insurance schemes	43 (5%)	39 (4%)	57 (6%)	66 (8%)	57 (6%)	57 (6%)
Household out-of-pocket payments	288 (33%)	287 (32%)	311 (35%)	321 (37%)	336 (36%)	351 (35%)
	883 (100%)	903 (100%)	888 (100%)	879 (100%)	941 (100%)	994 (100%)

Source CSO System of Health Accounts<sup>1</sup>

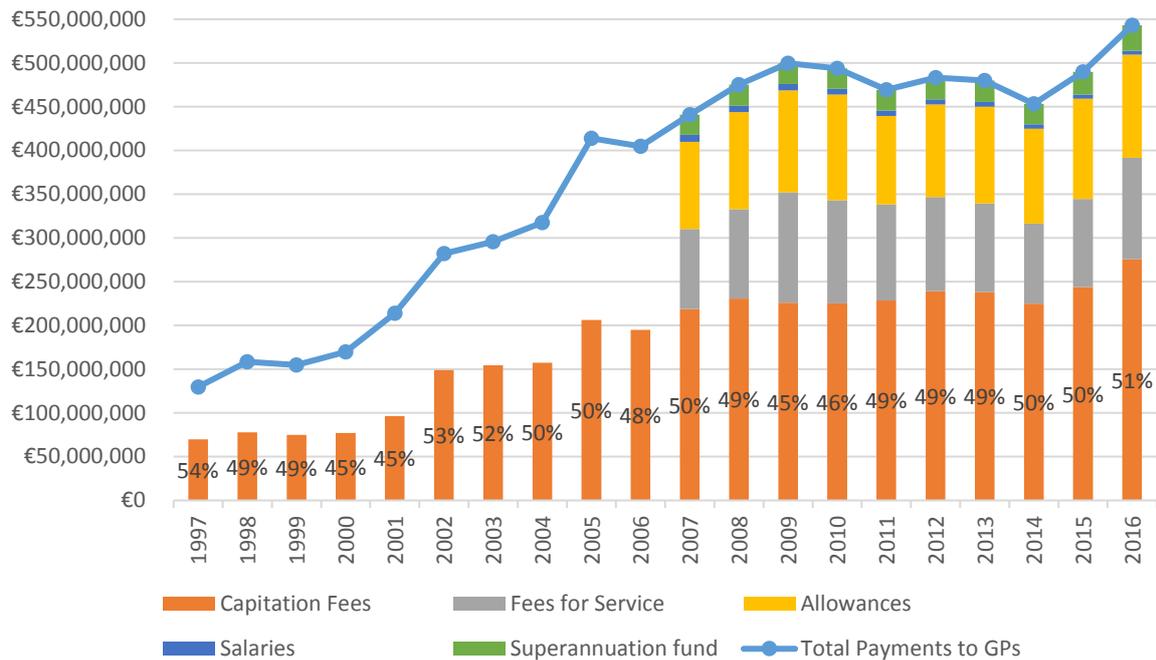
The bulk of Government financing for General Practice can be accounted for by the General Medical Services (GMS) contract for the provision of GP services free-of-charge to public patients i.e. Medical Card and GP Visit card holders. “While no high-level objectives have been formally set by the Department or the Health Service Executive (HSE) in relation to the GMS scheme, which was established many decades ago, the economic and social rationale for the GMS remains unchanged, i.e., to ensure that those people, who would otherwise be unable to arrange GP and medical services for themselves and their dependents without undue hardship, receive GP and medical services” (D/Health, 2011). The total cost of payments to GPs associated with the GMS payment including a number of smaller non-GMS schemes<sup>2</sup> (e.g. cancer screening, childhood immunisation and methadone treatment) is presented in the annual Primary Care Reimbursement Service (PCRS) ‘Statistical Analysis of Claims and Payments’ publication.

As per these reports, total payments to GPs in 2016 amounted to €543 million. This is an increase of €90 million on the 2014 trough of €453 million. Some 95% of the total PCRS payments to GPs has been accounted for by GMS payments in recent years (since 2009 at least). The moderation in the rates of increase in total PCRS payments to GPs over the past decade can be in large part be attributed to the reduction in capitation rates and allowances associated with the Financial Emergency Measures in the Public Interest Act 2009 (FEMPI) and the changing demographic composition of cardholders (Callaghan, 2015). These have counteracted the drivers of increases (population coverage, composition of population covered etc.) over the same period which are set out later.

<sup>1</sup> On the other hand, General Medical Practices are in receipt of non-health expenditures e.g. lease of practice premises.

<sup>2</sup> These specific purpose services are an example of public health schemes delivered through GPs which are not necessarily core primary care medical services.

## PCRS: Total Payments to GPs



Source: DPER Analysis of PCRS Reports, Statistical Analysis of Claims and Payments.

Capitation fees (Orange) paid to GPs in respect of Medical Card and GP Visit card holders account for half (51%) of total PCRS payments to GPs in 2016 at €275 million (An increase of €50 million since 2014). A particular value of GMS capitation fees is that it is guaranteed cash-flow which facilitates practice planning. Recent increases in capitation fees reflect, in particular, the expansion of the GP visit card to children under six from the middle of 2015.

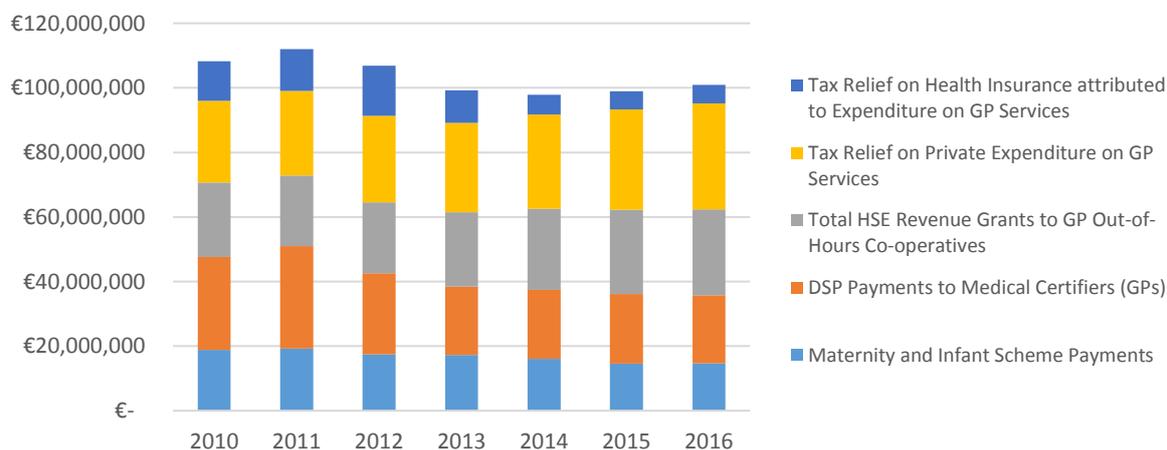
In the PCRS ‘Statistical Analyses of Claims and Payments’ reports, the Fees for Service and Allowances categories are further disaggregated into their subcomponents (not shown). The vast majority of fees for service (Grey, €116 million in 2016) have been and continue to be accounted for by Out-of-Hours payments (€38 million) and Special Type Claims/Services (€34 million, 2016). However, the main driver of fees for service increase since 2014 has been in other specific programmes introduced for Vaccinations, Diabetes and Asthma. These measures account for some €18 million of the €25 million increase in fees for service between 2014 and 2016. In respect of allowances (Yellow, €117 million, 2016), payments in respect of Secretarial/Nursing (€85 million, 2016) staff is and has been by far the largest component.<sup>3</sup>

<sup>3</sup> Expenditure on supports to GPs in respect of GMS patients will tend to also benefit the private patients of those GPs. For instance, while the allowance for Practice Nurses is graded depending on the size of the GMS panel, a practice nurse can equally treat GMS and private patients. An underpinning (founding) principle of GMS care is that there is no distinction between private and public consultations with a GP. As a result, GMS expenditure can in some ways subsidise private GP care.

### Other Government expenditure on General Practice

In addition to the PCRS, there are a number of further channels of state expenditure supporting General Practice some of which are more direct than others and some of which are more core to primary care than others. Among the most indirect forms of Government spending is the support for non-Government forms of Expenditure on GP services. Tax Revenues are forgone due to tax relief which is available at 20% to households on out-of-pocket medical expenses and on the purchase of health insurance. The ESRI (2010), used an estimate of twenty percent of the total cost of health expenses tax relief for the cost of tax relief on out-of-pocket expenditure on General Practice services. On this basis, after a sharp rise and fall from 2005 to 2010, forgone tax revenue in respect of GPs has been rising slowly and steadily in recent years from €25.5 million in 2010 to €32.8 million in 2016<sup>4</sup>. Similarly, a basic estimate of the tax revenue forgone on Medical Insurance in respect of General Practice would account for another €6m in 2016<sup>5</sup>.

Estimates of non-PCRS Government Expenditure on General Practice



Source: DPER Analysis of HSE Annual Accounts, Department of Social Protection, Revenue Commissioners - Costs of Tax Expenditures, Department of Health

On the other hand, direct payments to GPs under the Maternity and Infant Care Scheme (which are outside PCRS), for instance, account for some €15 million annually and can be very similar in purpose to GMS expenditure. Then there is expenditure on other supports for General Practice such as the approx. €25 million per annum on HSE Revenue Grants to GP Out-of-Hours Co-operatives.

Beyond the Department of Health and the HSE, there are Government Departments and Agencies which engage GPs for particular schemes. One of the largest expenditures (approx. €25m) in this regard relates to the fees GPs receive from the Department of Employment Affairs & Social Protection for medical certification services (i.e.

<sup>4</sup> I.e. 20% of the total €164m cost of Tax Relief on Health Expenses is attributed to private out-of-pocket expenditure on GP services.

<sup>5</sup> Health Insurers spend 1.75% of their health expenditure on Medical Practices. (OECD Voluntary Health care payment schemes 2013-2015) Assuming 1.75% of the total €329m cost of tax relief on Health Insurance premia in 2016 is attributable to medical practices yields an estimate of €5.8m.

illness, disability, carers and maternity payments). This payment is still direct though arguably less associated with primary (health) care.

With respect to Law, Justice and Defence, General Practice is funded through a few different Government channels. These include a free GP scheme for Gardaí, prison doctors directly employed by the prison services, general medical officers directly employed by the Defence Forces and payments in relation to medical examinations requested by Gardaí and attendance in court as an expert witness. Finally, a number of Semi-State bodies pay for free (or subsidised) GP for their staff e.g. CIE; An Post; Port and Docks Medical Officers (ICGP, 2010)<sup>6</sup>

Looking at parts of HSE expenditure not considered earlier, there are lines which are at least partially attributable to General Practice. The HSE directly employs General Practitioners generally in a number of roles including the full-time equivalent of some 80 GPs, over 90 GP Trainees and 10 Director and Assistant Directors of GP Training Schools. While GP trainees may be working in hospitals, some of the salaries on these positions should be attributable to General Practice and Primary Care. Similarly, the HSE has said that all directly employed GPs are employed in clinical policy advisor roles (Correspondence with D/Health, 6/6/2018). 80 WTE GPs would correspond to some 2.2% of all GPs engaged in such roles (D/Health - Health Service Capacity Review 2018 states 3,570 WTE GPs). The estimated pay cost of these General Practice roles in 2017 was €16.1 million (Authors calculation using HSE Pay Data). Attributing half of this pay cost to Government expenditure on General Practice, gives an estimate of €8 million.

HSE Direct Employment of GPs, GP Trainees and Training School Asst./Directors



Source: DPER Analysis of INFOR data

“The cost to the HSE in 2017 of delivering GP Training was €10.3M included €4.7M to Educators (i.e. the Claimants), another €4.7M to one-to-one GP Trainers and €0.9M of other costs, (mainly comprising cost of GP training Scheme Administrators who are primarily HSE employees). The budget for General Practice

<sup>6</sup> The relevance of many of these payments is that if subsidised GP care was to be extended to the entire population, these alternative forms of expenditure on General Practice could be curtailed and the savings returned to the State.

continuing medical education (CME) is under the remit of the HSE National Doctors Training and Planning Unit (NDTP). The current budget is in the region of €1m annually..” (Correspondence with D/Health, 6/6/2018)

Other smaller supports to General Practice would include HSE Revenue Grants to the ICGP, tax deductibility (as a cost of business) of GP membership and professional competence subscriptions to the Irish College of General Practitioners and the Irish Medical Organisation. Also, some of the expenditure on primary care centres, both direct build capital expenditure and those being delivered by Public Private Partnership and Lease agreements, will be attributable to General Practice.

#### **Government Mandated Private Expenditure on General Practice**

There are some forms of private expenditure on General Practice that are underpinned by Government requirements and regulations. For instance the requirement on individuals to get medical certification to gain access to other payments and public services can be a non-negligible source of private income to GPs. Across many countries “certification makes up a considerable proportion of GPs’ work...” (Cousins et al, 2016)<sup>7</sup>. The requirement for Eyesight and Medical Reports for Driving licences are further examples. In a similar regulatory vein are sick notes and the requirement for repeat prescriptions for items like the contraceptive pill and Statins.

Taking the most recent available outturn or estimate for each component then:

- |   |               |
|---|---------------|
| • Tax Relief on Health Insurance attributed to Expenditure on GP Services | €32.8m (2016) |
| • Tax Relief on Private (Out-of-pocket) Expenditure on General Practice   | €5.8m (2016)  |
| • HSE Revenue Grants to GP Out-of-Hour Co-operatives                      | €26.5m (2016) |
| • DEASP Payments to Medical Certifiers                                    | €21.1m (2016) |
| • Maternity and Infant Care Scheme  | €14.7m (2016) |
| • <u>Half</u> the cost of HSE Direct Employment of GPs etc.               | € 8.0m (2017) |
| • GP Training (incl. CME)   | €11.3m (2017) |

Combining the various estimates, yields a total of: **€120m**

In the context of PCRS payments of €543 million in 2016, this is a not insignificant amount.

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<sup>7</sup> Reducing time spent on medical certification is also a potential avenue for reducing the burden on the GP workforce and creating more capacity.

## Interaction of General Practice with non-General Practice Government Health Expenditure

There are considerable externalities involved in General Practice healthcare (as with all healthcare) as individuals (GPs/Practices) and patients don't accrue the full benefit or costs of the General Practice service. In other words, the GP doesn't internalise the costs or benefits of their decisions regarding treatment for other parts of the healthcare system. For example, the GP may refer patients onwards, or prescribe medications, without taking into account the broader costs or benefits of these decisions and implications for other healthcare users.

GPs (and other doctors) are principal gatekeepers of significant levels of Government spending through these channels and therefore can potentially significantly impact Government spending. In particular, GP decisions can have a considerable impact on Government (and private) health expenditures. Most obviously and directly this can be seen in Government (and private) expenditure on prescription drugs. This is one of the reasons for the recent focus on generic drug substitution.

Feely (1997) indicated that "while hospital doctors initiated only 8% of private prescriptions, they initiated 38% of GMS prescriptions, ...". While it is not the same figure, if the remaining 62% of prescriptions corresponded to 62% of the €945.9m cost of pharmacist drugs and medicines prescribed to patients under the Primary Care Reimbursement Service in 2016, prescriptions from General Practitioners would account for as much as €585 million.<sup>8</sup> GPs also play a role in reviewing prescriptions from hospital doctors when transcribing hospital prescriptions and checking for potential interactions with pre-existing medications. While these also serve a gatekeeping function such as avoiding wasting pharmaceutical expenditure, there are questions over whether more frequent reviews of prescriptions ultimately reduce or increase total costs when potential pharmaceutical savings are weighed against the cost of prescriber time, at least in the British National Health Service (Doble et al., 2017).

Additionally, in their role as gatekeepers to the Acute Healthcare system, GPs have a major role in influencing the costs on that system in terms of referring patients for hospital care (see for instance, Financial Incentives below). To the extent that GP interventions succeed in improving health (e.g. public health approaches), the burden of expenditure on more expensive forms of healthcare can, in theory, be prevented. However, the ESRI (2018) summarises that the evidence is mixed in terms of the capacity of GP care to substitute for hospital care.

GPs are also key gatekeepers of a number of social welfare allowances and (PRSI) benefits. It was noted earlier that GPs receive fees from the Department of Social Protection for their medical certification in respect of illness, disability, carers and maternity payments. As these payments amount to over €4,200 million in 2017 (DEASP, 2018) it can be easily seen that the amount of expenditure dependent on decisions by GPs is substantial.

Overall, it is clear that GPs act as gatekeepers not only to substantial expenditure in the broader health system but also to significant spending through social schemes. Conversely this gatekeeper role, to a certain extent

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<sup>8</sup> The cost of payments to pharmacists for drugs and medicines excluding dispensing fees and high tech drugs was €945.9m in 2016. (HSE, 2017).  $62\% \times €945.9m = €585m$

guarantees income flows to doctors. As identified earlier, there are questions to be asked of whether it is the best use of resources to have GPs fulfilling these kind of gatekeeper or reviewer roles (Doble et al., 2017).

### **Financial Incentives**

“The structure of financial incentives is crucial for improving efficiency and equity in health care.... For example, the distinction in provider payment method between public and private patients in primary care creates financial incentives on the part of GPs to treat public and private patients differently (with regard to follow - up visits, length of consultation, etc.). On the patient side, once a private patient has been admitted to hospital, it is often in his/her financial interest to avoid being discharged back to primary care.” (Nolan et. al 2011). For public patients, the financial incentive is for GPs to refer public patients to other parts of the health system.

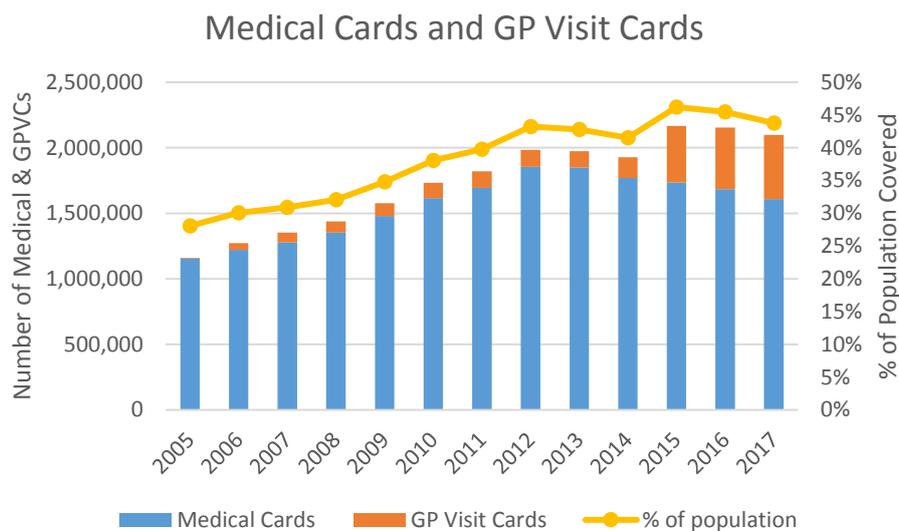
Similarly within Government expenditure on General Practice services there are different financial incentives depending on whether the scheme involved is capitation or fee per item/service based. The structure of financial incentives therefore raises the issue of potential crowding out among Government schemes. That is to say the possibility that the existence of one scheme detracts from the delivery of another. For instance, if the financial incentive for the GP is to spend more time on schemes with a fee per item or fee per service structure and less on those with a fixed payment, the presence of the former may reduce the effectiveness of the latter. For instance, it is possible the €21m of DEASP medical certification payments may represent value for money in its own right but it could possibly crowd out other PCRS expenditure. The extent to which certification may account for more GP time than the circa 3.4% of direct expenditure on GP services it represents, could indicate crowding out. The time requirement of the scheme is however unknown.

### **Drivers of Government expenditure on GPs**

The developments in expenditure on GPs discussed earlier have already identified what the long term and short term components that underpin expenditure are. Naturally the main long term driver of GMS expenditure on GPs is the number of Medical and GP Visit cards. Associated with the recession in Ireland, the proportion of the population falling eligible for Medical and GP Visit Cards expanded as more households’ incomes fell under the relevant thresholds. This pattern has reversed in recent years as incomes have increased. The increase in the number of cards in 2015 reflects the expansion of automatic entitlements to children under 6 and all persons over 70. Finally of note in recent years is the increase in the proportion of discretionary medical and GP visit cards (not shown). The number of discretionary cards fell from 97,000 (6.1% of the total) in 2009 to 76,000 (3.9% in 2013 and has doubled since then to 168,000 (8%) in 2017. As such, changing the income thresholds for eligibility, changing the policy around discretionary cards and changing the criteria around automatic eligibility<sup>9</sup> are some of the main levers for influencing Government spending on the GMS and ultimately General Practice.

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<sup>9</sup> By contrast to the first two approaches, changing criteria for automatic eligibility will tend to require new agreements with GPs.



Source: DPER Analysis of PCRS Statistical Analyses of Claims and Payments, Central Statistics Office

The expansion of services to include new programmes also plays a role in determining expenditure on GPs. In recent years, this has included expanded services related to chronic disease management (asthma and diabetes) and vaccinations. Finally, changes in the rates of payments will be a major determinant. In terms of tax relief, to the extent that Government can reduce the costs of GP care generally, that should help feed through (subject to bargaining power considerations).

#### General Practice Efficiency

There is very little available evidence on the efficiency of Irish Primary Care, in part due to a lack of data (ESRI, 2010; Dedeu et al. 2010). The ESRI (2010) identified Lordan’s (2007, 2009) work estimating “the efficiency of out-of-hours [OOH] co-operatives on the island of Ireland between May 2004 and May 2005” as the only known research.

The most conservative estimate of inefficiency from Lordan’s (2007) paper was 12.8% with the author citing an average annual inefficiency of 17% for OOH co-ops in the State. (The inefficiencies correspond to mean efficiency scores of 0.872 and 0.83 respectively). These estimates were subject to considerable caveats.

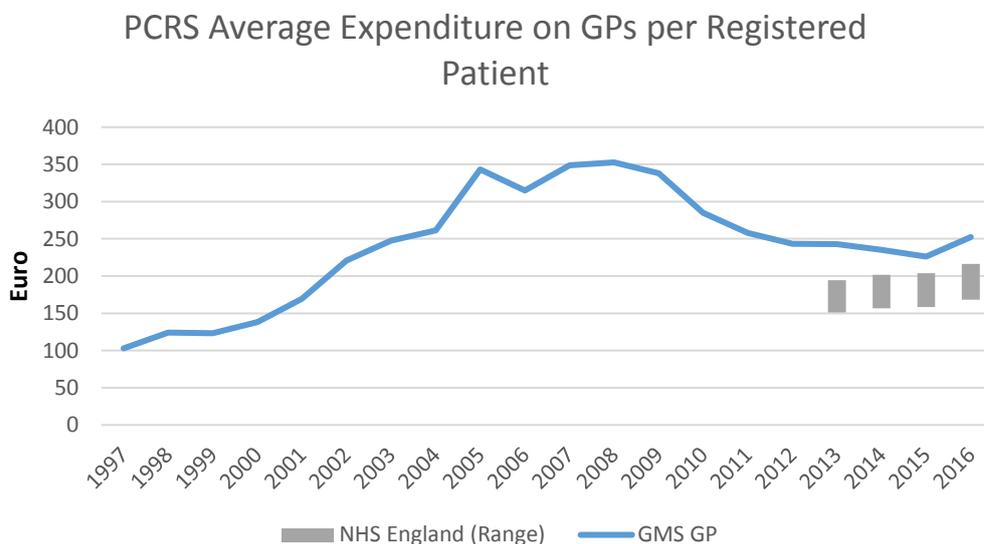
In particular, the use of nurse as opposed to doctor triage was associated with more efficient OOH GP cooperatives. This is consistent with Connolly et al. (2018) who estimated a potential 15.9 per cent reduction in GP costs if the proportionate use of nursing staff in General Practice in Ireland was increased to the rate in Northern Ireland. It is also consistent with the OECD who state that *‘Existing evaluations [of nurse practitioners in primary care] find a high patient satisfaction rate, while the impact on cost is either cost reducing or cost-*

neutral.’ (OECD Health at a Glance, 2017) and backs up the policy of increasing use of practice nurses in normal hours GP practice<sup>10</sup>.

Applying the same inefficiency estimates to total expenditure on GPs<sup>11</sup> in 2016 of €605 million would indicate potential savings in the order of €75 million to €100 million. In other words if the distribution of efficiency among GPs was the same as the distribution of efficiency among OOH co-ops identified by Lordan (2007), then bringing all GPs to the frontier of GP efficiency would mean that up to €100 million less would be required to deliver the same service. This could alternatively be used to deliver further services.

The main point here is the need for more analysis on the efficiency of primary care in Ireland. In the absence of more rigorous approaches, it is possible to look at GMS expenditure on GPs per Medical Card / GP Visit Card. However the various different other types of expenditure on GPs should really be taken into account here in combination with the extent to which these expenditures are intended to provide for public and private patients.

The development of average expenditure on GPs per registered patient (Medical / GP Visit Card holder) under the GMS is shown in the following chart. In 2016, the average cost per registered patient was €252, a level that has roughly held since 2011. By comparison, in euro terms NHS England expenditure on GPs in 2016 (£151.37) was in the range €168 to €216 per registered patient (at exchange rates €1 = STG £0.7 and €1 = STG £0.9). On this basis, the Irish rate per patient is between 50% and 17% higher than NHS England rates. Some of this difference will be accounted for by differences in the composition of patients covered by the schemes (i.e. the population covered by GMS would tend to have higher healthcare costs as compared to universal coverage in England) as well as the structure of GP practices (reflecting in part population distribution).



Source: PCRS Reports, NHS (2017)

<sup>10</sup> Of interest here is the different focus of the role of a primary care nurse i.e. whether the function of a practice nurse is to triage patients in advance of seeing the GP or to conduct services after/instead of seeing the GP (e.g. blood tests etc.).

<sup>11</sup> While the data corresponds to 2004-2005, before the HSE’s 2010 Review of GP Out of Hours Services, they might be generally closer to the frontier now... but not relevant if applying to GPs

## **Evidence of Inefficiencies in General Practice**

Examples of inefficient practice in General Practice can be seen for instance in the cases of inappropriate prescribing or where more appropriate prescribing is possible. For instance the HSE Medicines Management Programme's (MMP) 'Prescribing and Cost Guidance' initiative identified the "potential to make significant cost savings by both discontinuing lidocaine 5% plaster that are inappropriately prescribed or by switching patients to a more appropriately licensed alternative" (2017). The initiative also offers guidance in respect of 'Inhalers for Asthma (Adults and Children ≥6 Years)' and 'Inhaled Medicines for Chronic Obstructive Pulmonary Disease (COPD)' both of which offer "new therapies with equivalent efficacy offer the opportunity to save money for both patients and the state without compromising on safety and efficacy" (HSE 2016a, 2016b).

Similar initiatives from the HSE MMP include the 'Preferred Drugs' initiative and 'Prescribing Tips and Tools'. That there is a need for these initiatives is evidence in itself of inefficient GP prescribing. On the other hand the costs associated with this manifest in payments for drugs rather than payment to doctors.

It is hard to identify differences in practice that are outside medicine prescription. The Structure of General Practice Survey 2015, identified that GPs spend some 58% of their working time ('sessions') in direct patient-facing contact, 17% on Clinical Paperwork, 17% on Practice Management and 9% on Academic work (Authors analysis of TCD ICGP, 2016). Comparable survey data from Scotland would indicate that General Practice 'principals' there spent 89% of their time on clinical work, including paperwork (Authors analysis of McKinstry et. al, 2006). This compares to 75% (58% + 17%) in Ireland. While the structure of General Practice in Ireland is substantially different from Scotland (independent contractors vs employees), there would appear to be scope to increase the time GPs spend in clinical practice consulting patients and reduce the time spent on practice management.

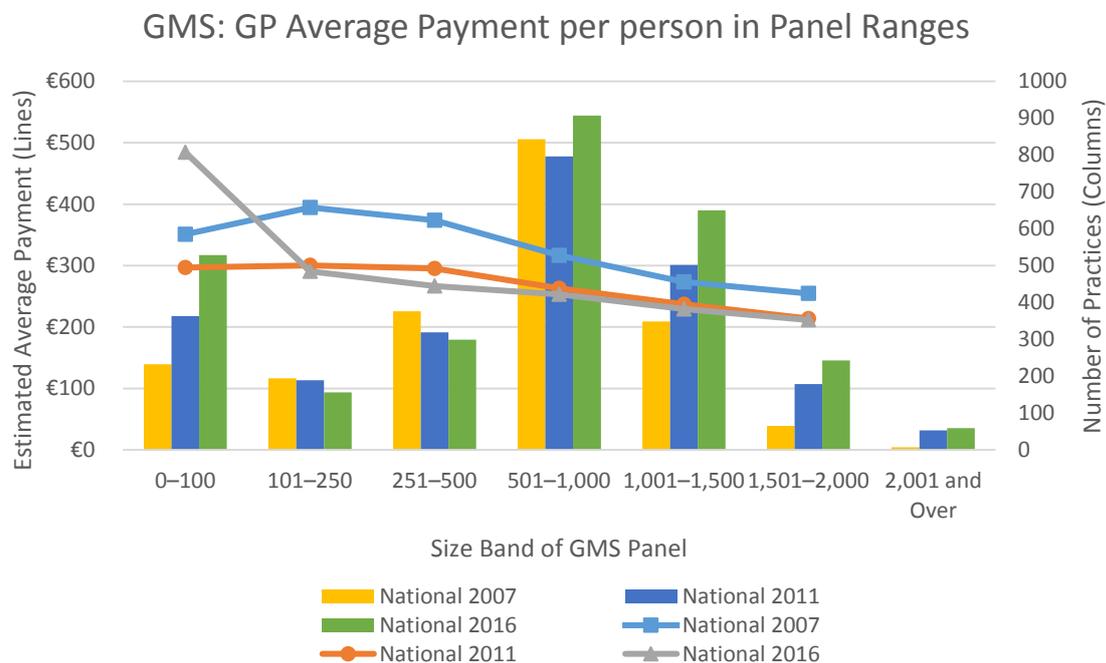
The combined 34% of time spent on clinical paperwork and practice management is consistent with survey research commissioned by the HSE. GPs reported very large administrative workload on GP practices (HSE & Coyne Research, 2017) including paperwork, difficulty reclaiming PCRS expenses, excessive processes for GMS consultant prescriptions and difficulty registering nursing home patients. Increased form filling/signing requirements were also highlighted. Reviews of the GMS prescription process and the PCRS system with an intention of reducing the administrative burden were resultingly recommended.

A review of red tape in General Practice from Australia highlights the findings of an Australian Medical Association survey that "general practitioners spend (on average) 4.62 hours per week or the equivalent of approximately 16 standard patient consultations negotiating red tape..." (Rural Health West, 2014). If a similar burden is assumed to apply in Ireland, the potential benefits of reducing red tape in General Practice become very salient.<sup>12</sup>

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<sup>12</sup> In Britain, the paper "Making Time in General Practice" (Primary Care Foundation and NHS Alliance, 2015) proposes "freeing GP capacity by reducing bureaucracy and avoidable consultations, managing the interface with hospitals and exploring new ways of working". This follows an earlier attempt by the British Cabinet Office's Public Sector Team Regulatory Impact Unit with their publication 'Reducing General Practitioner (GP)

In the HSE & Coyne Research (2017) smaller GP practices, without the potential for funding a practice manager, were most impacted by the paperwork burden. An examination of average payments per person provides an indicator of the potential of larger practices to provide care more efficiently:



Source: DPER Calculations from PCRS Annual Statistical Analysis of Claims and Payments

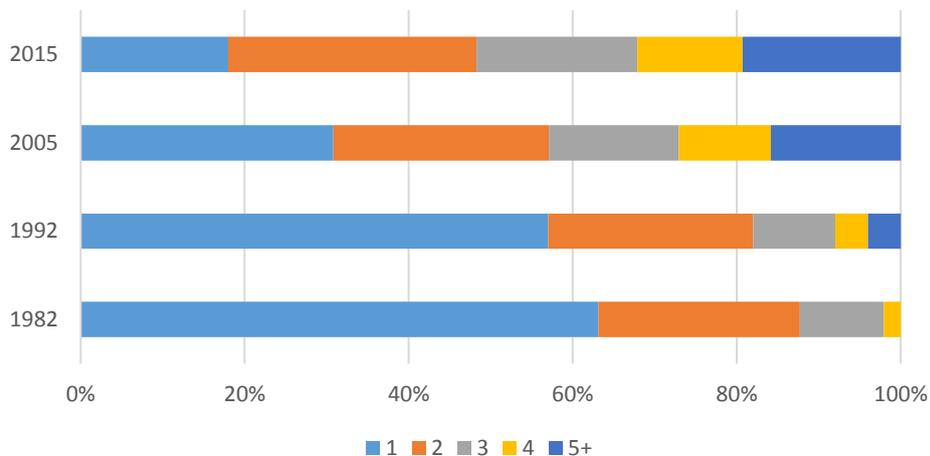
\*Average Payment per person calculated using midpoint of GMS Panel Band Size.

Under the current GMS structure, the average payment per person in the scheme is lower for practices with larger GMS panels (number of GMS patients attached to the doctor). It can be seen that, in general, the average payment per person has reduced since 2007 and that there has been a general shift towards larger GMS panels. This is consistent with a move towards more cost effective organisation of GMS practices.

This reorganisation towards larger practices can also be seen in the trend of the number of GPs working in the practice. (This will also reflect the increased proportion of GPs working part-time, who almost by definition will not be in single GP practices). As of 2015, single GP practices accounted for fewer than 20% of all practices, compared to some 30% a decade previous. Over the same period the proportion of practices with 3 or more GPs has increased from 43% to 52%.

Paperwork' (2001). The comparable body in Ireland is the Department of Business, Enterprise and Innovation's Business Regulation Unit whose goal is to find ways to reduce the administrative burden of regulation on business.

## Number of GPs working in the Practice



Source: Structure of General Practice in Ireland 1982-2015, 2016, TCD ICGP

There have been many previous reports which have included recommendations and findings which hold the potential to improve the efficiency of spending on GP services. These include the Department of Health Comprehensive Review of Expenditure 2011, the 2003 Review of Governance and Accountability Mechanisms in the General Medical Services Schemes (Deloitte & Department of Health, 2003) and Resource Allocation, Financing and Sustainability in the Health Sector (ESRI, 2010).

### Conclusions

The level of Government expenditure on General Practice includes a range of spending, not always recognised as such (and not always considered Primary Care), which sum to over €100 million in 2015. This is over 20% higher than the figure for total PCRS payments to GPs (€543m in 2016). The bulk of expenditure comes through the HSE PCRS in the form of direct payments to GPs. There are direct payments to GPs under other Department of Health schemes, which can be more or less comparable to GMS. Health expenditure on General practice also includes HSE Revenue Grants to GP Out-of-Hours Co-operatives and (some of the) expenditure on Primary Care Centres. It would seem appropriate to allocate a portion of the spending on education of GPs to General Practice.

Beyond the Department of Health and the HSE, there are a number of smaller expenditures by other Departments. Another further substantial channel of funding is the indirect payments to GPs through tax relief for out-of-pocket expenditure on GP services.

A key takeaway point here is that there is a myriad of lines of expenditure on General Practice. This has implications in terms of the potential that certain lines may become obscured when focusing on the principle channel, PCRS. For example, expansions in PCRS payments to GPs has the potential to increase (or decrease) expenditure on General Practice through these other channels.

It is also quite possible that the different schemes are compromising each other's effectiveness given their different objectives (Crowding out). The issue of whether GP resources are being used efficiently is raised by, for

instance, the primary use of GPs in delivering certain public health schemes and in the extent of their medical certification roles.

There is very little available evidence on the overall efficiency of Irish Primary Care and General Practice in Ireland and more work in this area is necessary. However, it is possible to identify some clear examples of areas where the efficiency of Irish General Practice can be improved.

Within the practice itself, there appears to be scope for efficiency improvements in terms of the time GPs spend not consulting patients and the time spent conducting consultations which do not necessarily require a medical practitioner (e.g. Certification). Greater use of practice nurses for triage and routine activities as well as other practice support staff would appear to be a key part of a move in this direction and the effectiveness of this approach in turn depends on increased practice sizes.

The most obvious and substantial areas where changes in General Practice has the potential to increase value for money for Government expenditure is through its interaction with other forms of health expenditure including drug prescription and gatekeeping for the acute healthcare sector.

More generally, measuring the efficiency of health expenditure on General Practice necessitates a clear statement of the goals of the various components of expenditure (e.g. expenditure on practice nurses) and weighting these goals within a defined overall objective. This links to the issue raised earlier of whether there are too many expenditure schemes which could potentially compromise each other's effectiveness and obscure the total level of spend.

Finally, as with all forms of evaluation, it is necessary to take the full extent of expenditure (including all additional forms of expenditure support) and its achievements in light of its objectives into account, before a conclusive assessment can be made.

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### **Quality assurance process**

To ensure accuracy and methodological rigour, the author engaged in the following quality assurance process.

- Internal/Departmental
  - √ Line management
  - Spending Review Steering group
  - √ Other divisions/sections
  - Peer review (IGEES network, seminars, conferences etc.)
  
- External
  - √ Other Government Department
  - Steering group
  - Quality Assurance Group (QAG)
  - Peer review (IGEES network, seminars, conferences etc.)
  - External expert(s)
  
- Other (relevant details)