



ICGP Pre-Budget Submission 2014

October 2013

About the ICGP

Established in 1984, The Irish College of General Practitioners (ICGP) is responsible for post graduate specialist medical education, training and research in the specialty of General Practice. The College has a national advisory role in relation to clinical standards and interacts regularly with a number of bodies including the Medical Council, Department of Health and Children, the Health Service Executive and the Health Information & Quality Authority amongst others. As a membership organisation the ICGP is responsible for providing continuing medical education (CME) for established GPs numbering over 2,500 at present.

The mission of the ICGP is to serve the patient, and its members / general practitioners by encouraging and maintaining the highest standards of general medical practice.

The core values of the College are quality, equity, access and service to the patient.

Alcohol Harm Reduction

Excessive consumption of alcohol in Irish society has generated well documented problems for individuals, families and society. Irish GPs encounter patients with problems related to alcohol misuse on a daily basis. The ICGP supports an evidence-based approach to the prevention of alcohol related problems.

The ICGP recently published a position paper on alcohol related problems in Ireland highlighting the scale of the problem and evidence for effective interventions (Finnegan & O' Riordan, 2012).

In 2007 the overall cost of harmful use of alcohol in Ireland was estimated to be €3.7 billion representing 1.9 per cent of GNP that year (Byrne 2011). In a recent Irish public opinion survey (HRB 2012) 85% of respondents thought that the current level of alcohol consumption in Ireland is too high.

Hope et al. (2005) concluded that between 20% and 50% of all presentations to emergency departments in Ireland are alcohol related, with the figure rising to over 80% at peak weekend periods. Binge drinking is a particular problem in Irish teenagers with 54% reporting that they have been drunk at least once before the age of 16 years (Children's Rights Alliance Report Card 2012). Alcohol plays a part in child protection and welfare issues with one in six cases of child abuse attributed to alcohol (Children's Rights Alliance Report Card 2012). A recent study on death by suicide in the Cork Region found that 35.9% had consumed alcohol at the time of suicide (Arensman et al. 2012).

From a GP perspective misuse of alcohol is a common contributor to serious physical, psychological and social problems in all age groups. Due to the long term relationship that GPs have with the majority of their patients they are in a unique position to witness the serious physical illness, psychological scars and family disruption caused by misuse of alcohol. GPs often care for several generations of one family and can testify first hand to the long term effects of alcohol misuse on families.

The ICGP wishes to emphasize the urgency for government in taking measures to reduce harmful alcohol consumption. Multiple studies have demonstrated that increasing the price of alcohol reduces alcohol consumption and related problems, including mortality rates, crime and traffic accidents (WHO 2007, Wagenaar et al. 2009, Anderson et al. 2009). Despite its apparent effectiveness, taxation as a method of reducing harm from drinking appears to have been under-used. Introducing a minimum price for alcohol can be complementary to an excise duty/ tax increase initiative. This success however is tempered by the degree to which illegal alcohol production and sale can be controlled. Many successful interventions restrict the availability and accessibility of alcohol. Restrictions limiting opening hours, locations and density of alcohol outlets have been shown to reduce harm.

Access to Diagnostics

The ICGP recently published a major report outlining the stark contrast between direct access to diagnostics for public and private patients (O' Riordan et al, 2013) For example more than 20% of GPs do not have direct access to either abdominal or pelvic ultrasound in the public system. Where access is available public patients have an average 14 week waiting period but this varied from one day to 42 weeks depending on geographical location. In stark contrast in the private system virtually all GPs have direct access to ultrasound with an average wait of just over four days. There is no doubt that as a result GPs are forced to refer patients inappropriately to overcrowded emergency departments in order to access diagnostic tests. This can be an unnecessary traumatic experience particularly for elderly patients and places an extra costly burden on hospital services. Patient access should be on the basis of need not on the ability to pay.

GPs are highly trained specialists who are currently constrained in their ability of deliver a quality service to their patients due to limited access to diagnostics in the public health system.

Irish GPs believe and international evidence concurs that increased access to diagnostics will lead to reduction in diagnostic delay, reduce the number of referrals to both emergency and outpatient departments, reduce unnecessary admissions and improve the quality of referrals overall. This in turn will lead to more effective use of the hospital services and improve the quality of service for Irish patients.

Chronic Disease Management

Chronic diseases are the leading cause of death and morbidity in developed countries. Most of the care of chronic disease in Ireland takes place in primary care (Department of Health and Children, 2009). Chronic disease accounts for a significant proportion of the disease burden and an increasing workload for GPs, accounting for up to 60% of visits by patients 45 years and older (Britt et al. 2009).

Primary care (with general practice at its core) has a central role in the management of chronic disease. Specialist care is best utilised for the management of patient with unstable conditions and the management of complications. Integration of care provision across acute hospital and primary care while developing the community services required to support the patient will make the best use of limited financial resources.

Most patients presenting to primary care have multiple problems – physical, psychological and social. Most clinical trials exclude patients with multi-morbidities. Primary care is best placed to address multi- morbidity as hospital based care becomes more and more specialised. GPs can integrate care, personalising care provision depending on the personal circumstances and capabilities of the individual patient and prioritising perceived problems (Heath et al,2009).In a recent Irish study, the main barriers to delivering chronic care are an increased workload and a lack of appropriate funding for chronic disease management (Darker et al, 2011).

GPs have shown that they are effective in the areas of prevention and health promotion through their participation in national immunisation programmes and Heartwatch, a secondary prevention programme for cardiovascular disease.

Heartwatch was commenced on a pilot basis with 20% of practices involved. Despite the research evidence showing that Heartwatch saves lives, and that secondary prevention works when resourced and carried out in a structured manner, the planned roll out to further practices as originally proposed has never occurred (McGrath et al, 2012).

Irish GPs have also demonstrated their ability to deliver on Diabetic chronic disease management in a structured care programme (Marsden et al, 2010).

ICGP requests of the Minister for Health that priority should be given to developing and funding services for patients with ischaemic heart disease and diabetes, based on lessons learned from “Heartwatch” and the Diabetes structured care programmes.

The development of the Clinical Care Programmes within the HSE has shown potential to improve chronic disease management. However, there has been no material commitment shown to date by the Department of Health or HSE to provide the necessary resources and

services to support the implementation of national clinical programmes to deal with the Chronic Disease Management needs of patients in the general practice setting.

Reallocation of funding from Secondary to Primary Care

The ICGP continues to work with the HSE and others towards the change to a primary care focused health system. The restructuring of the system leading to the provision of integrated services/care across Primary and Hospital Care is the agreed priority. However, to achieve this goal there must be significant investment in Primary and Community care, both personnel and infrastructure. Achieving this within the existing quantum of public funding for health will require a radical approach with transfer of funding and resources from the acute hospital sector to primary care. Funding needs to follow the patient in both community and hospital settings. The reduced demand on secondary care must be accompanied by a reduced budget with a transfer of those resources to the community. The process requires some dynamic decisions on the reallocation of resources to progress the transfer of care and services

Integrated e-health

Healthcare Information is the lifeblood of quality patient management. Irish General Practice has invested in Patient Information Management Systems. Ireland has some of the most innovative indigenous ICT companies working in the e-health space. The ICGP calls on the Minister or Health to ensure that appropriate health expenditure is allocated to accelerating ICT development in the health service particularly in relation to the long overdue need for an integrated patient management system across the primary secondary care interface. A ring-fenced, properly funded, e-health budget would incentivise innovation and integration of our health services sectors.

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