Trinity College Dublin
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The University of Dublin

Building a better GP and Primary Care service

Health summit

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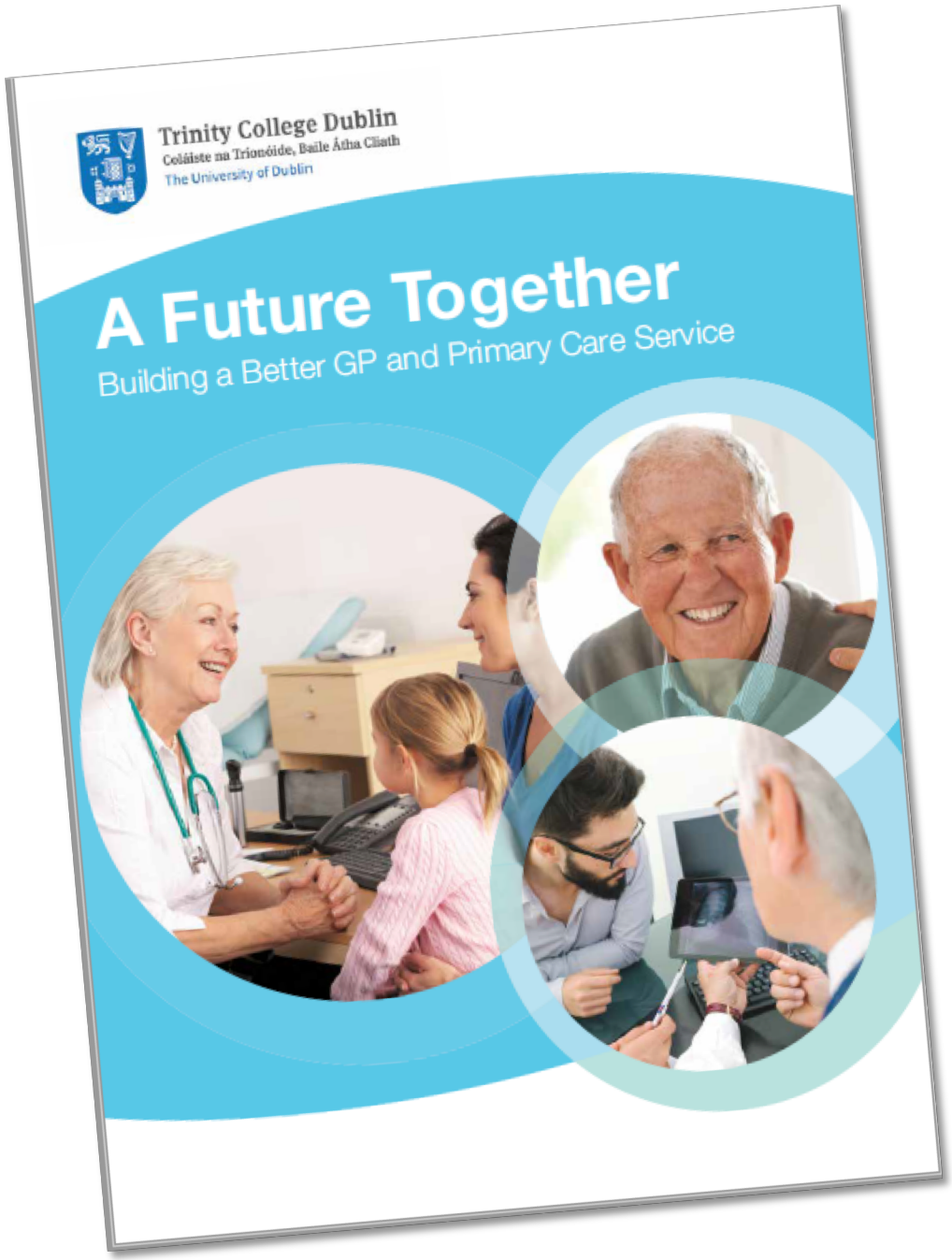

Tom O'Dowd
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www.hse.ie/eng/services/list/2/primarycare/gp-and-primary-care/a-future-together.pdf

Health reform programme

Government committed to

- free GP care at point of use
- Move away from acute model of care
- More preventative, planned, co-ordinated care
- Integrated primary and social care

System needs to be oriented to primary care : Slaintecare

Changes required in GP contract

How is GP in Ireland viewed internationally?

Long tradition and trust

Strong on personal long term care

Excellent training – 4 years post graduate

Good IT but not linked to secondary care

Reliance on fees viewed as extensive

- Restricts access

Coordination of care at early stages of development

What do patients think?

Over 90% satisfied

- Personal relationship and trust key drivers
- Most find it easy to find a GP
- Quality of communication good
- Love the practice nurse

Additional services

- Mental health
- Xrays and bloods on site
- Lifestyle advice

Current GP contract

Covers 40% of population

Seen as outdated

Limits 'can do' nature of general practice

International developments in limited use

- Multidisciplinary teams
- Disease registers
- Alerts and reminders

Ready for 'a decisive shift' to GP led primary care?

Evidence : better outcomes that cost less

Spending on primary medical care in Ireland

OECD 2014: % spend on 'medical practices'

- Public 2.6
- Private 1.9
- Total 4.5% - lowest of 5 countries

  = Total €856m on GP fees

- State payments €543m (PCRS & HSE 2014)
- Private spend 315.6m

  or 63% of spend on 40% of population

  - significant underspend by 60% of population (private practice)

GP consultation rates

Consult rate:

- GMS 5.63 pa
- Non GMS 2.69 pa

GMS patients are sicker

But …. fees deter private patients from seeing the doctor

International approach is towards tax based or insured care and away from fees

Staffing

Ireland: 6.26 GPs / 10,000 patients

- Similar to Denmark, Germany, the Netherlands

Practice support staff

- Lowest of 10 countries
- Low hanging fruit here

Long term illness

Single disease management works

- But most of us have 2 or more
- Evidence is less clear

Guidelines aplenty

- Not geared to multiple illnesses
- May result in over treatment/investigation/referrals
- Not following them lays doctors open to criticism

Long term illness – the secret sauce

Seeing the same doctor makes a difference

- High continuity of care – 12.5% fewer hospital admissions

Continuity of care means

- Practice geared up for this
- Register, reminders, ‘on the look out’
- Staff training
- Home visits
- Reducing locums
- TIME – the real currency of the GP

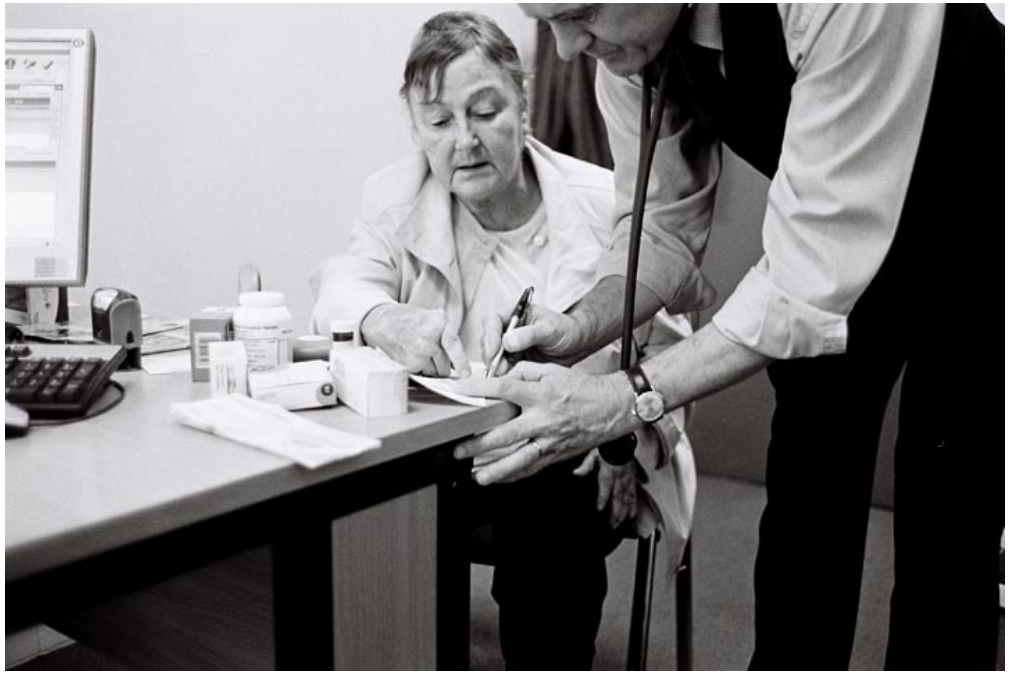
Chronic disease *vs* long term illness

Hospitals see chronic diseases

- In ones and twos
- In various OPDs
- In various institutions
- With various files

GPs see long term illness

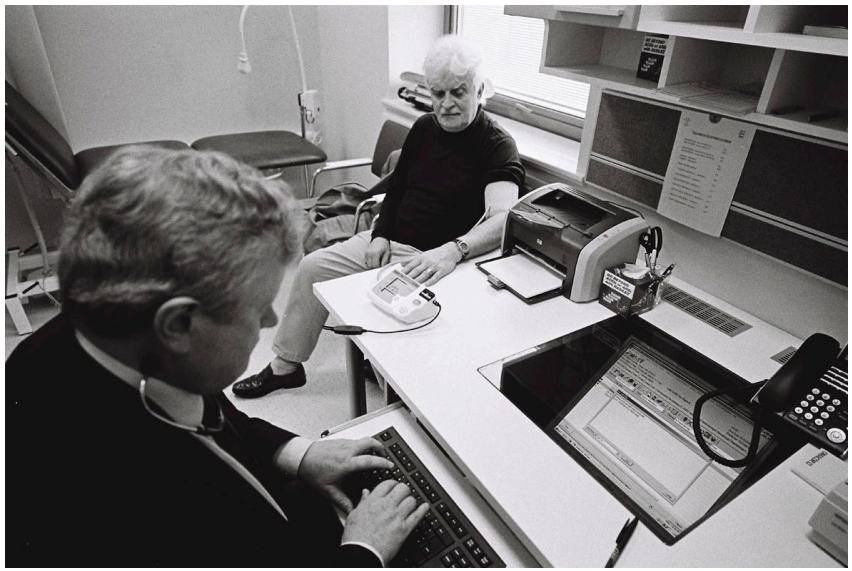
- In the same patient
- In the same practice
- With the same staff



Information technology

Most GPs use IT

- Healthlink for labs
- Healthmail secure email
- eReferrals



Links with hospitals are patchy

Some patient usage for email

Telemedicine – niche interest but growing

- Driven by insurers in UK

Use of data

Linked to good modern IT

One of the challenges of this project

People in Ireland tech savvy

- Reliance of the old fax in hospital and GP….

Build disease registers

- Call and recall

Need an agreed data monitoring unit

- To make good cases to stop things and start new things

Do young GPs want out?

Focus day

- 70 x 3rd and 4th year registrars
- Want to work in multidisciplinary teams
- Better access to radiology
- IT links to hospitals
- A career structure
  - Salaried x few years
  - GMS principal
  - Managing partner

None wanted out – or single handed practice

- Medical careers are tough everywhere
- The Netherlands seem to have happier GPs

Will GPs be able to cope with new work?

GP appropriate for

- Management of undifferentiated illness
- Long term conditions and the frail
- Clinical and practice leadership
- Developing the case for relevant services

Time is scarce and needs to be managed

- If someone else in the team is more appropriate for this patient then the GP is freed up
- ‘top of the licence’

What about other professionals?

Pharmacists: see sharing of aspects of chronic disease mx

- Development of clinical pharmacy

AHPs

- Physio – back pain certs
  - GPs in training want to include:
    - Advanced nurse practitioner
    - Social worker
    - Psychologist
    - Practice pharmacist

“Making it happen for Paschal”

‘Era3 of healthcare’: we’re all on the same side

– Don Berwick

Transitional funding: making time for:

- Long term illness care
- Diagnostic services
- Linked IT
- Practice staff
- Data monitoring unit

Insurers need to provide primary care product

- Poor involvement in/understanding of GP

Quick wins – Vermont and N Carolina

- Practice staffing – driven by need

Connecting the pieces

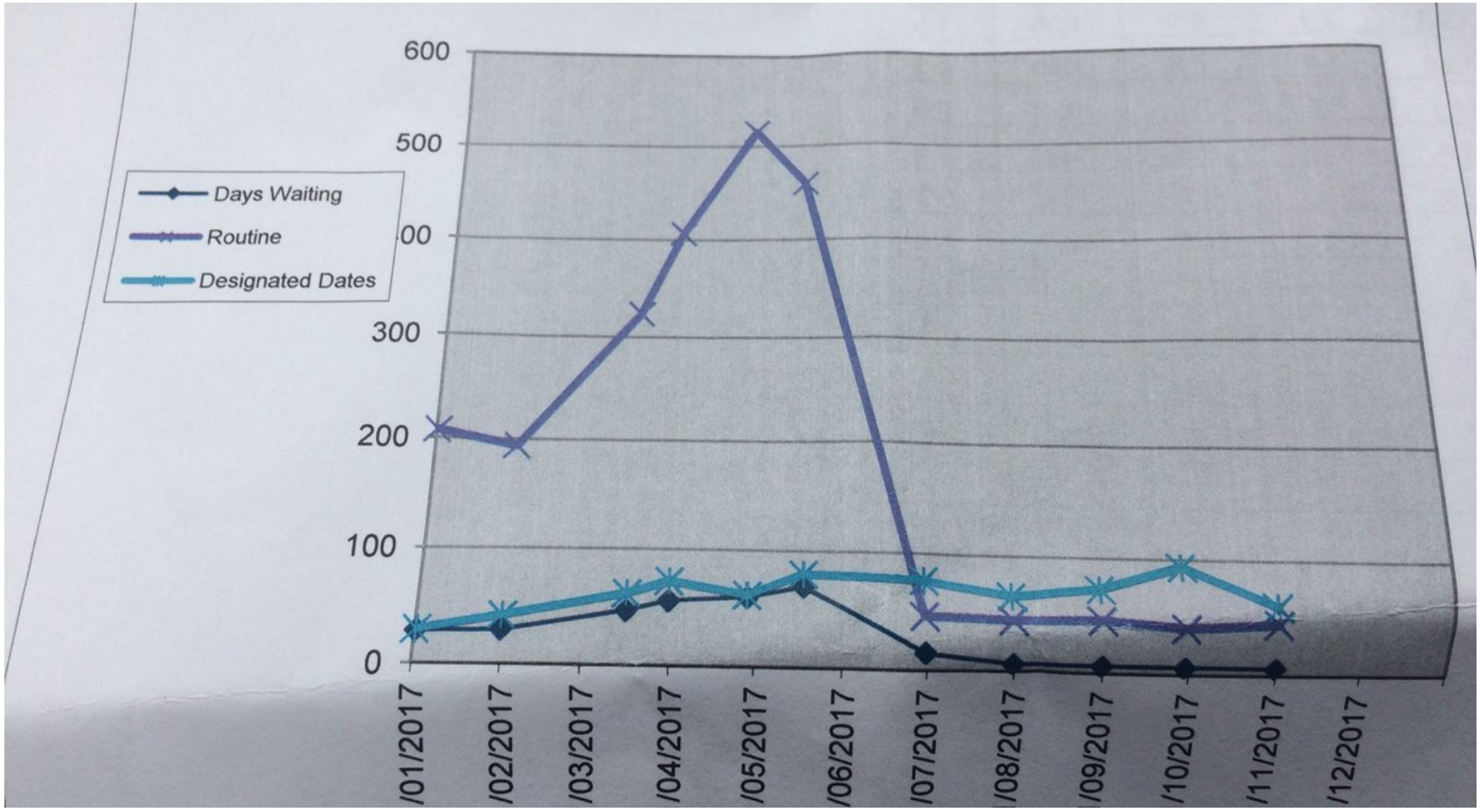
For GPs

- Giving up stuff – that someone else can do
- Taking on new stuff – upskilling
- Core: continuity of care

For practices

- Need to be stabilised on business lines
- Remove fear of employing staff
- Expanded infrastructure – premises, IT

Quick Wins : Primary care radiology in Castlebar @simonharrisTD



But most of all it needs…

“A philosophical, political and financial shift away from institutional and often inappropriate secondary care”