IMO Submission to Department of Health Public on the Scope of Private Health Insurance to incorporate additional Primary Care Services.

January 2015

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
Tel (01) 676 72 73
Email : vhetherington@imo.ie
Website www.imo.ie

IMO Submission to Department of Health on the Scope of Private Health Insurance to incorporate additional Primary Care Services.

The IMO is the representative body for all doctors in Ireland and is committed to a caring, effective and efficient health service. The IMO welcomes the opportunity to comment on the Department of Health Public Consultation on the Scope of Private Health Insurance to incorporate additional Primary Care Services.

The Public Consultation takes place in the context of the Government's emphasis on developing Primary Care services including GP services and its commitment to extending access to GP services to the whole population on a phased basis.

The benefits of a strong Primary Care system are well documented. General Practice and the Community Care services that make up Primary Care are associated with better health outcomes, equity of access, more appropriate utilisation of services, long-term cost effectiveness and increased patient satisfaction[1] [2] [3] however these benefits can only be achieved with both a substantial increase in the level of funding for healthcare as well as an increase in the level of resources allocated to General Practice and Community care services.

Under *Future Health - A Strategic Framework for the Reform of the Health Service 2012-2015* the Government is committed to reforming the model of care so that 90-95% of healthcare needs are met in Primary Care. The Government has promised GP care free at the point of access for all, the development of chronic disease management in Primary Care supported by a new GP Contract and capital provision for the development of Primary Care centres.

The IMO supports the Government's goal to extend access to GP care to the whole population provided that it is accompanied by careful planning and accompanied by the appropriate level of financial, infrastructure and manpower resources.

For a number of years now the IMO has been at the forefront advocating for a universal health system that aims to secure access to adequate, quality healthcare for all when they need it and at an affordable cost. However, the IMO has consistently expressed grave concern about the reliance on private health insurance to fund universal healthcare. A market model only serves the interests of private health insurers and corporate providers and their shareholders. The IMO is particularly concerned with the corporatisation of Primary Care under such a model and its impact on the quality of healthcare in Ireland.

The key strengths of the current independent contractor model of General Practice include: value for money; continuity of care; gate-keeping; high patient satisfaction; equity of access; flexibility in responding to health crises as they arise; extensive network of GP centres of practice and easily accessible service. By contrast, the corporate model of Primary Care offers poor value for money and poor quality of care. Particular issues include: failure to provide continual care; 'cream-skimming';

---

[1] Starfield B. Shi L and Macinko J, Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502)
[2] Atun R, What are the Advantages and Disadvantages of Restructuring a Health System to be More Focused on Primary Care Services? Copenhagen, WHO Regional Office for Europe, Health Evidence Network report ; January 2004
[3] Kringos DS, The Strength of Primary Care in Europe, NIVEL 2012

inability to deal with long-term complex illnesses; double doctoring; increased diagnostics; increased referrals and access issues.

The IMO is particularly concerned about this apparent change in policy direction to expand access to GP care through private health insurance. Few countries finance universal health care through private health insurance and the IMO is not aware of any countries that have used separate private health insurance (PHI) plans as a means of expanding access to Primary Care. Given the evidence presented below the IMO would have serious reservations about relying on PHI to fund such an integral part of our healthcare services.

There is evidence that the political processes and tendencies in a jurisdiction can influence both the expansion of universal health coverage and the development of Primary Care.[4][5] Given Ireland's more liberal regulatory and political environment we are more likely to emulate the American healthcare system than the Dutch.

There are other mechanisms for funding healthcare and the IMO insists that the country will be better served by expanding the existing tax-funded model or with careful planning and resources introducing a system of social health insurance.

At the same time, the IMO recognises that in all healthcare systems funded either through taxation or social health insurance, a demand for private health insurance and private health care will always exist. In the context of a supplementary or complementary role for PHI in the Irish market there are clear benefits to expanding the scope of PHI to cover GP and other ancillary services in Primary Care. In fact the IMO is surprised that in the context of apparent increased competition in the PHI market that no PHI providers have sought to develop a competitive edge by extending cover to GP and PC services.

However a PHI insurance funding model for Primary Care is not conducive to the aims of *Healthy Ireland: A Framework for Improved Health and Well-being 2013-2015* to increase the proportion of people who are healthy at all stages of life and to reduce inequalities in health.

Universal health care NOT Universal Health Insurance

The IMO supports the introduction of a Universal Healthcare system that aims to secure access to adequate, quality healthcare for all when they need it and at an affordable cost. However it is important not to confuse Universal Health Insurance (UHI) with Universal Healthcare as UHI is simply a financing mechanism.

The model of UHI as proposed in the White Paper introduces a system of compulsory private health insurance based on the Dutch model with competing public and private health insurers purchasing healthcare on behalf of individuals from competing public and private healthcare providers.

Healthcare is both a public good and a scarce resource. The proposed model, in effect, introduces the Market Model of Healthcare provision under which healthcare becomes a private good regulated by the state. Once healthcare is handed over to private enterprises this scarce resource becomes complex to manage and extremely difficult to take back.

[4] Savedoff W.D. et al, Political and Economic aspects of the transition to Universal Health Coverage, The Lancet 2012, 360 : 8 ; 924-932

[5] Kringos D. 2012

In May 2014, the IMO made an extensive submission on the White Paper on Universal Health Insurance. Highlighting the evidence from the US and Netherlands, the IMO raised serious questions on the ability of the chosen UHI model to deliver on

- Affordability
- Equity of Access
- Choice
- Timely Access to Care
- Quality of Care and Value for Money

Affordability

Under a market model, healthcare becomes a commodity and the interests of private corporations and their shareholders ultimately take priority over the provision of patient care. Costs become impossible to control as private providers and insurers vie for clients to increase turnover and market share on more profitable care while restricting access to more complex, cost-intensive care in order to contain costs.

Both the Netherlands and the US have seen significant growth in for-profit clinics specialising in low cost out-patient procedures raising concerns about supplier induced demand. In the Netherlands, the rapid rise in healthcare costs following reform has been attributed in part to the growth of Independent Treatment Centres specialising in freely negotiable low-cost elective procedures.[6] Reuters[7] recently reported that private equity firms have been ploughing millions into urgent care walk-in clinics as they expect profits to grow as health reform will extend the numbers covered by health insurance by 30 million in the next decade. Industry experts have advised that urgent care clinics should keep their services simple to maximize profitability. "clinics could lose money if they spend time with patients or take on complicated health problems because insurance companies generally reimburse at a flat rate for each visit". "It's not complex, critical-care medicine. It's a low-tech, high-touch business."

Market-based systems also necessitate a whole level of regulatory, administrative and marketing costs that are not required in other funding systems and which drain resources from the provision of patient care. In the US healthcare administrative costs are far higher than in any other country and American insurers spend $606 per person[8] on administration costs alone while hospital administration costs account for 25% of hospital costs in the US and 20% in the Netherlands compared to 16% in England and 12% in Canada. [9]

It is no coincidence that countries, which rely on private health insurance to fund healthcare are among most expensive healthcare systems in the OECD. In terms of per capita spending, health

---

[6] Maarse H and Paulus A. The Politics of Health-Care Reform in the Netherlands since 2006, *Heath Economics, Policy and Law* 2011 :6 : 125-134

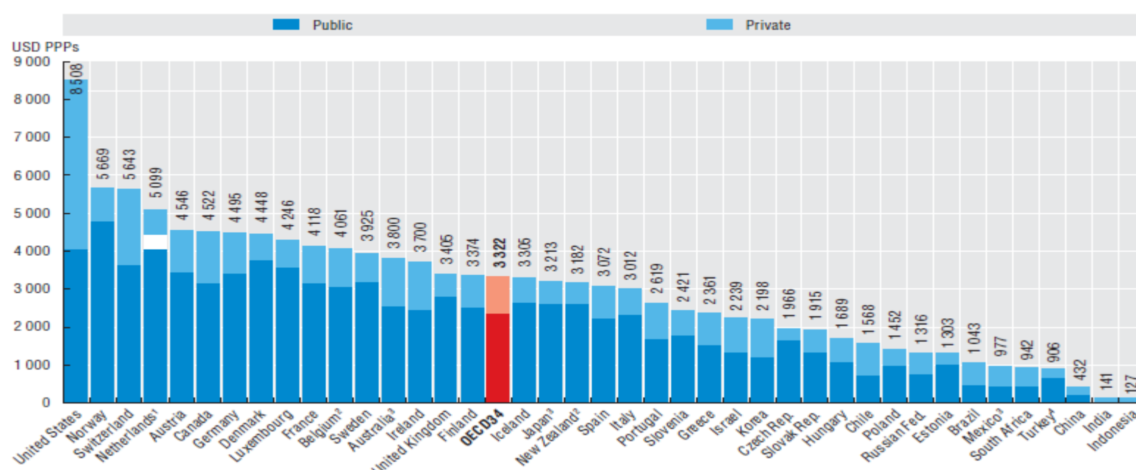
[7] Atossa. A.A. Analysis: Private equity funds rapid growth of walk-in clinics, Reuters. NEW YORK Mar 21, 2013. Downloaded from http://www.reuters.com/article/2013/03/21/us-usa-health-clinics-idUSBRE92K04W20130321

[8] Schoen C. Osborn R. Squires D & Doty M.M. Access, Affordability, and Insurance Complexity Are Often Worse in the United States Compared to 10 Other Countries The Commonwealth Fund November 2013 published in Health Affairs December 2013 32:122205-2215

[9] D. U. Himmelstein, M. Jun, R. Busse et al., "A Comparison of Hospital Administrative Costs in Eight Nations: U.S. Costs Exceed All Others by Far," Health Affairs, Sept. 2014 33(9):1586–94

expenditure is highest and more than double the OECD average in the US, followed in third and fourth place by Switzerland and the Netherlands.[10]

Per capita health expenditure US$PPP – OECD Health at a Glance 2013



The White Paper sets out a number of core measures to control costs and a second set of reserve measures to be set out in legislation but only implemented as required. The IMO would have serious concerns about the ability of such measures to control costs.

Recent efforts to contain costs in our own private health insurance market has failed. Four companies now operate in the PHI market in Ireland, yet PHI premiums have been rising at an average rate of 10% substantially greater than both inflation and health inflation.

The IMO also believe that the reserve measures, which involve capping of insurers overheads, profit margins and claims expenditure, if implemented private insurers may no longer see the benefit in remaining in the market and may potentially exit having reaped the benefits for a period. Although it is questionable whether Government will legally be able to cap the profits of private insurers. Under the Transatlantic Trade and Investment Partnership which is currently being negotiated between EU and US, US companies may be able to sue the State for any new laws which affect their profits.[11]

Equity of Access

If the proposed model is adopted in Ireland, there is a real danger that a two-tier system of healthcare will be exacerbated and effectively institutionalised. In order to contain costs and keep with in budgetary requirements the Government will be obliged to restrict the standard basket of care and impose high out-of-pocket co-payments for care. As a result we will simply be reshuffling our two-tier system of healthcare to a system where those who can afford supplementary private health insurance will have access to a wider range of care while those without are limited to a standard basket of care with high out of pocket co-payments.

In order to contain cost in the Netherlands the minimum basket of services covered has been gradually reduced and a mandatory deductible of €350 per annum applies to all care except GP visits. As a result the majority of people in the Netherlands (85% of the population according to the

[10] OECD Health at a Glance 2013

[11] http://europa.eu/rapid/press-release_IP-14-292_en.htm?locale=en

Dutch Healthcare Authority) purchase supplementary and complementary private health insurance to cover care outside the basket as well as the mandatory deductible.

In the US, the Affordable Care Act has sought to expand PHI coverage to the uninsured through subsidies for families below 400% of the federal poverty level and state insurance exchanges which offer lower cost private health insurance packages to individuals and small businesses. Concerns about the quality of insurance cover have been raised, as under the most commonly purchased plans annual deductibles typically exceed $US 2,000 per person insured and likely have a significant impact on healthcare utilisation.[12] While cost-sharing is transparent it is often less clear what providers are covered in the plans.

A recent survey by the Commonwealth Fund[13] found that one in three US adults spent a substantial amount of time dealing with insurance paperwork or disputes and were either denied payment for a claim or paid less than expected. These problems applied to one in four adults in Switzerland and one in five in the Netherlands.

Access to care can also be restricted geographically. The cost of providing care in rural and deprived areas can be significantly higher than urban wealthier areas. Market conditions incentivise healthcare providers to locate in areas where potential clients are both healthier and wealthier, leaving deprived and rural areas under-served. In the US large sections of the population have inadequate access to healthcare. In the US large sections of the population have inadequate access to health care.

- About 71 million people live in areas designated by the federal government as Medically Underserved Areas (MAUs)[14]
- About 65 million people live in regions without adequate Primary Care, designated by the federal government as Primary Care Health Professional Shortage Areas (HPSAs).[15]
- A report by the National Association of Community Health Centers found that 56 million Americans have inadequate access to a Primary Care physician and could be considered "medically disenfranchised," out of the even larger number of people who are considered medically underserved because they live in shortage areas or face financial, linguistic, or other challenges to accessing Primary Care.[16]

The number of GPs is unevenly distributed across regions. Attracting GPs to urban deprived and rural areas is already an issue. Due to inequalities in health the visitation rates and workload is higher in deprived urban areas and many practice are overstretched. [17] Most sophisticated health systems allocate resources to General Practice which take into account patterns of co and multi- morbidities

---

[12] Rice T et al, Challenges facing the United States of America in implementing Universal Coverage, *Bull World Health Organ* 2014;92: 894-902

[13] Schoen C. Osborn R. Squires D & Doty M.M. Access, Affordability, and Insurance Complexity Are Often Worse in the United States Compared to 10 Other Countries The Commonwealth Fund November 2013 published in Health Affairs December 2013 32:122205-2215

[14] Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and Health Professional shortage Areas, Final Report to the Secretary 2011 downloaded fromhttp://www.hrsa.gov/advisorycommittees/shortage/nrmcfinalreport.pdf

[15] The Commonwealth Fund, State and Federal Efforts to Enhance Access to Basic Health Care, States in Action Newsletter, March-April 2010 downloaded from http://www.commonwealthfund.org/Newsletters/States-in-Action/2010/Mar/March-April-2010/Feature/Feature.aspx

[16] National Association of Community Health Centers *Access Denied: A Look at America's Medically Disenfranchised* , , March, 2007 in The Commonwealth Fund 2010 above

[17] Teljeur C. et al, The distribution of GPs in Ireland in relation to deprivation, *Health & Place*, doi:10.1016/j.healthplace.2010.06.011

and GP utilisation in areas of deprivation. The number of doctors working in rural areas has declined from 33% in 1990s to 22% in 2005,[18] and the geographical area covered by rural doctors is widening. Only a minority (7.1%) of rural inhabitants can walk to their GP.[19] Failure to provide weighted capitation payments based on deprivation and removal of distance coding as a factor in capitation payments under FEMPI makes it increasingly unviable for GPs to work in deprived urban and rural areas. If the proposed model of financing is introduced these inequalities in GP coverage are likely to increase as corporate practices locate in wealthier urban areas in search of economies of scale.

Choice

The proposed system as outlined may also restrict patient choice and lead to rapid closures of smaller health facilities throughout the country. Under the UHI system health insurers will be free to establish their own healthcare centres (vertically integrate) or selectively contract with larger corporate providers in order to cut costs, thus restricting choice to patients. The inevitable closure of smaller facilities will leave rural and deprived areas further underserved.

Managed Care, through Health Maintenance Organisations (HMOs) or Preferred Provider Organisations (PPOs), was introduced in the US in 1990s in order to cut costs. Managed Care requires patients to verify coverage with their insurer before undergoing any treatment and restricts patient choice to the HMO or PPO network.

In the Netherlands some insurers, such as Menzis, are beginning to open their own primary-care centres to lower costs for those it insures[20] and those who purchase the basic package can be restricted to certain hospitals or face paying between 20-50% of the bill if they choose a non-contracted hospital.[21] A recent Bill proposed by the Dutch Prime Minster to cut healthcare costs by €1bn by restricting patients to contracted healthcare providers was defeated as it would restrict patient choice. [22]

Timely Access to Care

There is no guarantee that a new financing mechanism can deliver timely access to care. Access to care is a capacity issue and there is insufficient capacity in the Irish healthcare system. Successive budget cuts since 2009 have reduced the Health Service budget by 27% or €4bn,[23] staffing levels have been reduced by 11% or 12,812 WTEs since peak levels in 2007[24] and the number of acute hospital beds in the system has decreased by 1,631 or 13%.[25] Efficiencies have been exhausted and recent HSE performance reports have shown that hospital waiting lists for outpatient and elective care are rising again as are the number of patients waiting on trolleys in Emergency Departments and wards. There is no measurement of the impact successive budget cuts and manpower constraints have had on quality of care and patient safety.

---

[18] Teljour C. et al, General Practitioner Workforce Planning: assessment of four policy directions *BMC Health Services Research,* 2010 10: 148

[19] Teljeur C. et al, The distribution of GPs in Ireland in relation to deprivation, *Health & Place,* doi:10.1016/j.healthplace.2010.06.011

20 Daley C. Gubb J. Healthcare Systems:The Netherlands, Civitas Updated 2013

[21] Gowling A, Cheap Health Insurance Carries Large Risks, Dutch News

[22] Deutch A, Dutch PM agrees to change health bill to avoid government collapse, Reuters downloaded from http://www.reuters.com/article/2014/12/18/us-netherlands-politics-crisis-idUSKBN0JW0OR2014121

[23] HSE National Performance Assurance Report March 2014

[24] HSE, Annual Report and Financial Statements 2013

[25] DOH Key Trends 2013

Private hospitals can provide additional capacity, however private hospitals generally provide low cost more profitable elective care, while public and voluntary hospitals will continue to treat patients with more expensive complex emergency or chronic care with declining resources.

General Practice and Community Care in Ireland is suffering from significant under-resourcing. General Practice which is at the centre of all Primary Care systems is now dealing with over half a million additional Medical card and GP visit card patients while €160m has been withdrawn from General Practice over the last 4 years. While operating at full capacity, GPs struggle to provide a same-day service. The expansion of free access to GP care without an increase in financial and manpower resources will inevitably lead to waiting lists.

There is no infrastructure in place to support multi-disciplinary team-working and there are insufficient Community Care professionals to cope with current demand under the GMS. Waiting lists apply for all allied health and social care services in Primary Care and many of these services are simply not available to patients outside the GMS regardless of their ability to pay.

General Practice and community care services in Primary Care are associated with better outcomes, equity of access, increased patient satisfaction, more appropriate utilisation of services and long-term cost effectiveness. [26]However the benefits can only be achieved with an increase in the proportion of funding allocated to General Practice and Primary Care services.

Quality of Care and Value for Money

There is also no guarantee that a market model will deliver quality care or value for money. The Dutch healthcare system ranks high in terms of patient satisfaction and outcomes are good however this is a result of 30 years of investment particularly in General Practice and Community Care and not a result of the financing mechanism. Outcomes were good before the financing system was introduced in 2006. There are still wide disparities in the cost of care and little information available on the relationship between cost and quality of care.

The US healthcare system has led to innovation and some care is excellent, but quality of care is inconsistent and overall outcomes are poor. The federal government provides funding and technical assistance for the development of community-based health centres, not-for-profit facilities that provide health care to low income, underinsured and underserved populations.[27] These State funded Community health care centres have been found to outperform private health maintenance organisations (HMOs) on continuity of care, coordination of care, comprehensiveness of services and community orientation.[28]

It has been recognised that the US Primary Care suffers from chronic under-resourcing. The Affordable Care Act includes a number of provisions to invest in Primary Care primarily through the State funded Medicare and Medicaid systems and not through private health insurance[29].

Financing Universal Healthcare

There is more than one system for financing healthcare such as a tax-based model or a social health insurance funded model. Both systems have their pros and cons. The IMO believes that with

[26] Starfield, 2005, Atun 2004, Kringos 2012
[27] The Commonwealth Fund 2010
[28] Starfield B, Shi L, The Medical Home Access to Care and Insurance: A Review of Evidence, Paediatrics 2004: 113; 1493
[29] Abrams M et al, Realizing Health Reform's Potential: How the Affordable Care Act will Strengthen Primary Care and Benefit Patients, Providers and Payers, The Commonwealth Fund January 2011

incremental increases in resources and careful planning the goal of universal healthcare can be delivered under an expanded taxation model or eventually under a system of social health insurance. The IMO would like to see the debate brought back to how we can best provide universal healthcare with open debate and consensus on the most appropriate funding model for our country.

At the same time the IMO recognises that in any universal healthcare system there will always be demand for private health insurance (PHI) and that there are benefits to ensuring the coverage of GP and community care services in voluntary supplementary or complementary private healthcare plans.

Consultation Questions

With regard to the specific questions posed in the consultation document:

1. What is the optimal level of cover for primary care services and GP services that would be available in private health insurance contracts?

The IMO is opposed to mandatory private health insurance as a means of financing public healthcare, however in the context of a supplementary and complementary role for private health insurance there are clear benefits to expanding the scope of PHI to cover GP and other community care services in Primary Care.

The IMO supports the universal health coverage whereby all residents in Ireland should have access to appropriate 'promotive, preventive, curative and rehabilitative healthcare'[30]. This means that all residents should be entitled to medically necessary care in the public system including prescription drugs, hospital and GP services as well as services such as public health services and long-term care services. A strong General Practice and community care system in Primary Care system is associated with better health outcomes, equity of access, more appropriate utilisation of services, cost effectiveness and increased patient satisfaction.[31] All citizens should be able to receive care in community with a doctor of their choice. If individuals choose to insure themselves privately, the Minimum Benefits Package should be comprehensive and include all medically necessary care including all primary, secondary and tertiary care services with the doctor of their choice.

2. Are there any measures that the State should take to mandate or incentivise the provision and/or purchasing of such cover?

The IMO is opposed to the reliance on mandatory purchase of private health insurance as a mechanism for financing public health care in Ireland. As mentioned above the IMO does not believe that a system of mandatory private health insurance can deliver on

- Affordability
- Equity of Access
- Choice
- Timely Access to Care
- Quality of Care and Value for Money

[30] WHO Achieving Universal Health Coverage: Developing the Health Financing System *Technical Briefs for Policy-Makers No. 1* 2005
[31] Starfield, 2005, Atun 2004, Kringos 2012

There are alternative models to financing healthcare and the IMO believe that the country will be better served by expanding the existing tax-funded model or with careful planning and resources introducing a system of social health insurance.

At the same time, the IMO recognises that in all healthcare systems funded either through taxation or social health insurance, a demand for private health insurance and private health care will always exist. Individuals should be free to purchase supplementary or complementary health insurance and as such PHI should remain voluntary.

In the context of a voluntary supplementary or complementary role for private health insurance, as currently exists in Ireland the IMO is surprised that providers of PHI have not seen the advantage of covering GP and PC services within health insurance plans. The State can mandate the cover of these services in the voluntary private health insurance market through minimum benefits regulations (See question 3 below).

3. Should any cover be compulsory (e.g. as part of the minimum packages that insurers must offer) or optional?

The IMO is opposed to mandatory private health insurance as a means of financing public healthcare, however in the context of a voluntary supplementary and complementary role for private health insurance there are clear benefits to including GP services and other community care services in Primary Care within the minimum benefits package.

The purpose of Minimum Benefits Regulations together with Risk Equalisation in PHI markets is to support community rating - whereby the cost of a particular level of cover is same for all insured lives, irrespective of age, sex or health status. Therefore the aim of Minimum Benefits Regulations is to prevent risk selection and risk segmentation whereby insurance companies design packages aimed at lower risk individuals or groups, or example younger healthier people rather than older sicker people. Minimum Benefits Regulations must guarantee inter-generational solidarity. Therefore the range of benefits provided by health insurers needs to be sufficiently comprehensive to ensure that the medically-necessary services relevant to each group are equally represented.

4. Should primary care cover be in a separate health insurance plan or as part of in-patient plans?

As per question 3 above, in the context of a voluntary complementary and supplementary role for PHI, Minimum Benefits regulations should provide that all health insurance plans cover Primary, Secondary and Tertiary Care services. Failure on behalf of PHI providers to cover Primary Care services as part of in-patient plans creates the incentive for purchasers of PHI to use the hospitals system rather than GP or Community Care services. In order to encourage purchasers of PHI to use the Primary Care system, GP and other Community Care Services must be part of in-patient plans.

Few countries rely on mandatory private health insurance as a means of financing healthcare and the IMO is not aware of any developed country that has used separate private health insurance plans to expand access to Primary Care services. Given the evidence relating to the use of mandatory private health insurance as a funding model it would be foolish for Ireland to experiment with healthcare funding in this way.

5. To what extent should limiting terms be allowed (e.g. number of visits allowable, the amount payable per visit etc)?

Private health insurers include limiting terms in PHI contracts in order to reduce moral hazard. Moral hazard refers to a situation whereby patients who do not have to bear the full cost of medical care

may be inclined to consume more care than is necessary knowing that their insurance company will pick up the bill. Similarly providers may tend to over prescribe care or treatment knowing that the patient's insurance will cover the cost.

Limiting terms may include co-payments for care, restriction on the number of visits allowed, and restriction on choice of doctor. However the use of limiting terms in a healthcare system primarily financed through PHI can have negative repercussions accentuating inequalities in health and access to care and restricting patient choice.

A recent report from the European Commission Expert Panel on Effective Ways of Investing in Health found that co-payments for health care have been found little evidence that user charges lead to more appropriate use or are effective as a cost control measure.[32] Even when charges are low they have been found to deter patients from seeking and complying with both necessary and unnecessary care and treatment, leading to delayed diagnosis and increased hospitalisation. Co-payments are also highly inequitable as they apply only to sick people at the point of use and impact disproportionately on elderly and lower income groups and patients with long-term illness.

Is should be noted that in the Netherlands the €350 deductible does not apply to GP care and in the US the Affordable Care Act eliminated co-payments and deductibles for preventive care services and tests such as blood pressure and cancer screening, mammograms, pap tests and immunisation in order to encourage people to obtain preventive care[33].

Restrictions on the number of visits allowed has the same effect as co-payments for care. Patients who exceed the restricted number of visits allowed are forced to pay out of pocket for care. The profile of patients that require regular visits to their General Practitioner are generally patients with long-term illness, elderly patients or patients from deprived socio-economic groups.

Restricting choice of doctor restricts Continuity of Care that is a cornerstone of General Practice.

> *Continuity of care allows health professionals to get to know patients. This has been found to be associated with time saving, reduced referrals, reduced prescriptions and improved compliance. The literature also shows that continuity of care is associated with improved recognition and management of patients' psycho-social problems.*[34]

Continuity of care is also an essential part of chronic disease management. The close relationship between GP and patient that develops over time allows GPs to better detect changes in health status, the provision of preventative care and patient conformity to therapy suggestions from the GP[35]. Research also suggests that good patient-physician continuity is 'associated with a decreased likelihood of future hospitalization, as well as decreased emergency department use'[36].

Restricting choice of doctor to contracted corporate providers disrupts that continuity of care and can result in constant recounting of complex symptoms, an increase in referrals for diagnostics and

---

[32] EC EXPH, Definition of a frame of reference in relation to primary care with a special emphasis on financing systems and referral systems, European Commission 2014 downloaded from http://ec.europa.eu/health/expert_panel/opinions/docs/001_definitionprimarycare_en.pdf

[33] Abrams M et al, 2011 Op cit

[34] Department of Health (DOH) Primary Care – A New Direction, 2001

[35] Bolton, P. Sustaining Quality General Practice in a Flawed Market. Australian Family Physician, Vol 32. No 4, April 2003.

[36] Mainous III AG. *Continuity of care and trust in one's physician: evidence from primary care in the United States and the United Kingdom.* In: Baker R, editor. 2000 North American Primary Care Research Group Meeting; 2001 January 2001: Fam Med 2001; 2001. p. 22-7.

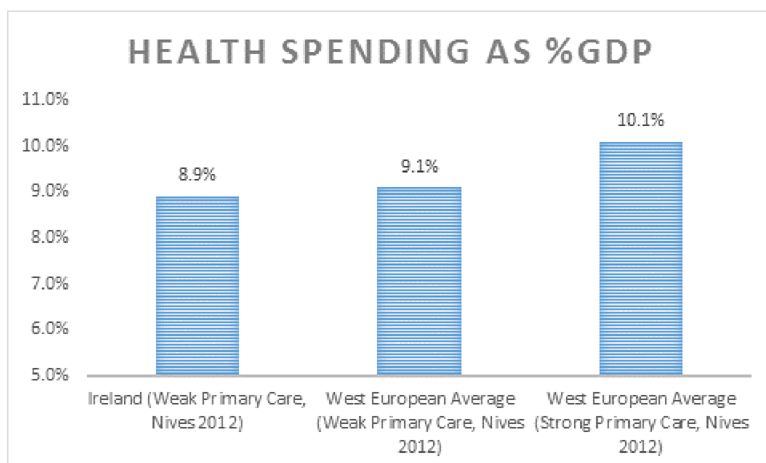
for admission into hospital, dramatically increasing patient cost and placing pressure on an already overstretched healthcare system.

As mentioned above a recent Bill proposed by the Dutch Prime Minster to cut healthcare costs by €1bn by restricting patients to contracted healthcare providers was defeated as it would impact on patient choice. [37]

6. How can we encourage a real transfer of provision of services from the acute hospital setting to primary care, so that we are not simply adding to volume and costs?

Recent research on Primary Care in Europe found that countries considered to have a strong Primary Care system have universal access with little to no out-of-pocket payments, strong governance arrangements including obligatory registration with a GP and a GP gatekeeping role, provide a comprehensive range of services and invest in the development of the workforce. [38]

While a strong Primary care system is associated with slower growth in health care spending it is not associated with low overall health care spending. Western European countries considered to have a strong Primary Care system (Belgium, Denmark, Finland, The Netherlands, Portugal Spain and the UK) spend a greater % of GDP on healthcare and can spend up to 10% of the overall health budget on General Practice and a further 10% on ancillary community care services in Primary Care. [39]



Chronic disease management is not taking place in our hospitals. There is a 3-year wait in Beaumont Hospital and a 2 year + waiting list in the Mater Hospital for Diabetes Shared Care. Other CDM Programmes developed by the ICGP are new programmes designed to prevent future hospitalisations.

Developing a strong Primary Care system in Ireland is not about the simple transfer of resources from the hospital setting to General Practice and Community Care. Our hospital system is

---

[37] Deutch A, Dutch PM agrees to change health bill to avoid government collapse, Reuters downloaded from http://www.reuters.com/article/2014/12/18/us-netherlands-politics-crisis-idUSKBN0JW0OR2014121

[38] Kringos DS, The Strength of Primary Care in Europe, NIVEL 2012

[39] In 2004-2005, 10.33% of the British NHS budget was spent on general practice by 2011-2012, this figure had declined by almost two percentage points to 8.4%. See http://www.rcgp.org.uk/news/2013/november/patient-care-compromised-as-funding-for-general-practice-slumps-across-the-uk.aspx, Nivel database estimates the total spend on PC in the UK 2006-07 at 19.9% . See http://www.nivel.nl/en/dossier/country-information-primary-care

overstretched and it is unrealistic to think that we can expand access to GP care to an extra 2.6 million people and introduce new Chronic Disease Management Programmes without a substantial increase in resources.

Between 2009 and 2014 Health Service funding has been reduced by 27% or €4bn[40] and staffing levels have been reduced by 11% or 12,812 WTEs since peak levels in 2007[41] and the number of acute hospital beds in the system has decreased by 1,631 or 13%.[42] In the meantime demand on the hospital system has risen with ED, Inpatient, outpatient and day case activity increasing steadily. According to the OECD Curative bed occupancy rates in Ireland on average are 92.6% (2012) well above the recommended safe occupancy rate of 85% applicable in some countries[43] and just over the tipping point of patient safety (estimated at 92.5% bed occupancy), whereby clinical staff become more prone to error due to rationing of resources and elevated stress levels.[44] Serious concerns have been raised about patient safety in our hospitals from all professionals working in our hospital system from Doctors and nurses to hospital managers. Our hospital system requires an increase in funding in order to stabilise services, not a reduction in funding to finance new Primary care services.

7. What is the capacity of GP practices to deliver insurance-funded primary care of the type suggested here?

General Practice in Ireland is significantly under-resourced and does not have the capacity to deliver on a private health insurance-funded model.

- General Practice now cares for over 500,000 additional medical card and GP visit card holders while resources have been cut by 40% or €160m over the past 4 years;
- The Government spends just 2.3% of total expenditure public and private on General Practice compared to 9% in the UK;
- Ireland is facing a GP manpower crisis:
    - 260 GPs (12% of the GMS workforce) are 64 years or over and are due to retire;
    - many newly qualified GPs are emigrating - 1049 Irish trained GPs have taken up principal posts in the UK NHS (these GPs as well as being GMS principals were the locums and assistant that allowed flexibility in supply of GP healthcare allowing for leave or the development of additional services);
    - GP services in rural and deprived areas are in need of urgent remedial management with many GMS posts left unfilled;
- There is no infrastructure in place to support multi-disciplinary team working and there are insufficient community and primary care professionals to cope with current demand under the GMS. Waiting lists apply for all allied health and social care services in Primary Care[45] and many of these services are simply not available to patients outside the GMS regardless of their ability to pay;

Currently 2,414 GPs deliver care to over 2 million GMS patients, 24 million clinical consultations and 1 million out-of-hours consultations take place each year. 95% of consultations are dealt with by the

[40] HSE National Performance Assurance Report March 2014
[41] HSE, Annual Report and Financial Statements 2013
[42] DOH Key Trends 2013
[43] OECD Health at a Glance 2013
[44] Kuntz L. Mennicken, and Scholtes, Stress on the ward: Evidence of safety tipping points in Hospitals, Management Science, May 2014
[45] HSE National Performance Assurance Report March 2014

GP without need for referral to secondary care. GPs currently provide a same-day service 24/7 and 365 days a year. Private health insurance companies cannot be relied on to expand GP services to the remaining population or to appropriately finance new Chronic Disease Management Programmes. It is also unclear how the new Community Healthcare Organisations are to be funded under Universal Health Insurance or how PHI can support integrated care. The White Paper suggests that some community and social health services including public health nurses may be funded separately through taxation. Different funding mechanisms for certain community and social care services are likely to increase fragmentation of care.

While the Netherlands appears to provide an example of how a private health insurance funded model might be compatible with a strong Primary Care system, it is important to note that mandatory PHI was only introduced in the Netherlands after substantial investment over three decades in the quality of care in Family Medicine and Primary Care.[46] For example, the Dutch College of General Practitioners (DCGP) has developed over 90 clinical guidelines for family medicine and over 50 for interdisciplinary care. The DCGP has also developed a practice accreditation programme. All Family Practices have a system of EMRs which allows patient information to be transferred electronically to hospitals and allows access to patient records out of hours. Many GPs work in group practices or multidisciplinary health centres. Solo and group practices also engage in large scale collaboration including collaboration for the provision of out-of-hours services. There has been substantial expansion of the workforce to include physician assistants and practice nurses.

As mentioned above it has been recognised that the US Primary Care suffers from chronic under-resourcing. The Affordable Care Act includes a number of provisions to invest in Primary Care primarily through the State funded Medicare and Medicaid systems and not through Private health insurance. Provisions include increased reimbursement rates under Medicare and Medicaid, grants and incentives to support the development of medical homes and accountable care organisations, increased funding for Federally Qualified Health Centres,[47] scholarships to encourage more primary care physicians to work in underserved rural and urban areas as well as various programmes to train and employ more nurses.[48]

Multi-payer PHI funded systems are not necessarily able to deliver consistency in terms of cost and quality of care in new Chronic Disease Management Programmes. In 2007 the Netherlands introduced bundled payments for on an experimental basis for diabetes care and since expanded bundled payments to COPD and CVD risk management. Insurers pay a single fee to a "care group" to cover a full range of integrated chronic disease care services. A care group usually consists of a number of care providers (often exclusively GPs) who assume clinical and financial responsibility for all assigned patients, delivering care themselves or subcontracting with other care providers. The price of the bundle is freely negotiated between insurers and care groups and between care groups and subcontracted providers.

A one-year review of bundled payments to diabetes care groups found that rates charged under bundled payment contracts varied widely from €258 to €474 per patient per year and were explained in part by differences in care provided.[49] All bundle payments conformed to standards of care as established by the Dutch Diabetes Federation in terms of recommended number of check-ups, laboratory examinations and annual eye and foot examinations while differences lay in

[46] Van Weel C, Schers H, Timmerman A, Health Care in the Netherlands, JABFM, 2012 Vol 12 Supplement
[47] Abrams M et al 2011 Op cit
[48] Rice et al 2014 op cit
[49] Struijs J.N. Baan C.A. Integrating Care through Bundled Payments NEJM 2011 364:11

additional GP consultations, guidance on smoking cessation or foot care. Inexperience of both insurers and providers in setting prices is also thought to have contributed to the price variation however variations persisted in 2008, 2009 and 2010 indicating that standards were being interpreted in different ways by insurers seeking to stint on costs. [50]

Greater consistency in cost and quality of care can be achieved in a single payer model where the state negotiates the terms of a contract of care with the IMO as the representative body for GPs in Ireland.

8. Any other comments on the proposal for private health insurers to cover a fuller minimum range of services provided by GPs?

The IMO has specific concerns in relation to any proposal to for PHI to fund universal access to Primary Care. In a number of jurisdictions market forces have led to the corporatisation of Primary Care where subsequently quality and cost of care has been compromised by corporate imperatives.

A number of jurisdictions such as Canada, Australia, the UK, the US and more recently the Netherlands have seen the development of walk-in clinics that specialise in low-cost ambulatory care, often filling a gap between ED and GP services and offering out-of-hour services without appointment.

In Canada and the UK walk-in clinics have been criticised for “cream skimming” more profitable care, lack of continuity of care and “double doctoring” whereby patients tend to follow up with their regular GP leading to a duplication of services and costs.[51] [52]

In Australia and the have had particular concerns with the vertically integrated practices and the propensity for corporate priorities to influence ethical standards of doctors as well the volume and direction of referrals. [53] As Primary Care services often yield less profitable results corporate Primary Care providers may also establish more profitable diagnostic or specialist hospital services. A recent report published by the Australian Department of Health and Ageing[54] highlights a number of studies which show how the profit motive and corporate pressure has influenced the direction of referrals particularly to pathology and diagnostic services. In the US, Stark Law restricts referrals of Medicare and Medicaid from physicians to a hospital in which he or she has a financial interest. New provisions under the Affordable Care Act also restrict the expansion of physician owned hospitals, and require physicians to disclose to their patients if they have any financial interest in a hospital and whether it provides 24-hour emergency care. [55]

---

[50] Struijs J.N. Baan C.A. 2011 ibid
[51] Weinkauf, D, Kralj, B. Medical Service Provision and Costs: Do Walk-In Clinics Differ from Other Primary Care Delivery Settings, Canadian Public Policy – Analyse de Politiques, 1998 Vol. XXIV, No 4
[52] Monitor, Walk-in centre review: preliminary Report Monitor 2013, www.monitor.gov.uk
[53] AMA GP Super Clinics Initiative – Comments on the draft Program Overview, Australian Medical Association, 15 April 2008,
[54] Medicare Financing and Analysis Branch, State of Corporatisation - A Report on the Corporatisation of General Practices in Australia, Department of Health and Ageing, February 2012
[55] Virtual mentor, American Medical Journal of Ethics, Feb 2013 15: 2: 150-155