PRV / Public

HbA1c + BNP

Irish College of GPs

Audit Report

Public vs Private Patient Monitoring in General Practice:

A Comparative Audit

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Declaration: This clinician-led audit of anonymised patient data did not require ethical approval and received no funding. All data were extracted and analysed within participating general practices as part of routine quality improvement activities.

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1. Background

The Chronic Disease Management (CDM) programme, introduced under the HSE's Enhanced Community Care (ECC) suite, provides structured care for patients with chronic illnesses in general practice. Engagement with the CDM programme for their public (GMS/DVC) patients has been strong among Irish GPs. However, private patients, who pay out of pocket, may not be enrolled in the programme.

This audit aimed to compare monitoring practices between public and private patients with chronic diseases in general practice, focusing specifically on two high-burden conditions: type 2 diabetes mellitus (T2DM) and heart failure (HF). We examined the frequency and outcomes of two key tests associated with these conditions: HbA1c (for glycaemic control) and BNP/NT-proBNP (for cardiac function).

2. Methods

Nine GPs distributed nationally participated in this audit, each reviewing the records of 20 adult patients from their practice: 10 public patients (GMS or DVC) and 10 private patients.

All selected patients had an existing coded diagnosis of T2DM (E11) and/or heart failure (I50) and, were aged between 18yrs and 69yrs. This age range was chosen to ensure adequate representation from private patients. CDM is available to all public patients over 18yrs of age and there is automatic entitlement for public GP care when patients reach 70yrs of age.

For each patient, the following data were extracted:

- Number of HbA1c tests performed in 2024
- Most recent HbA1c value

- Number of BNP tests performed in 2024
- Most recent BNP value
- Whether the latest BNP result was within normal range (Y/N)

This was a pragmatic, clinician-led audit to identify potential disparities in monitoring and outcomes between patient groups.

3. Results

A total of 178 patient records were returned (90 public, 88 private) from 9 GPs within 8 practices distributed across 4 of the 6 HSE Regions (C- 40, D- 80, E- 40, F- 18). Patient age was broadly matched across groups (see Figure 1).

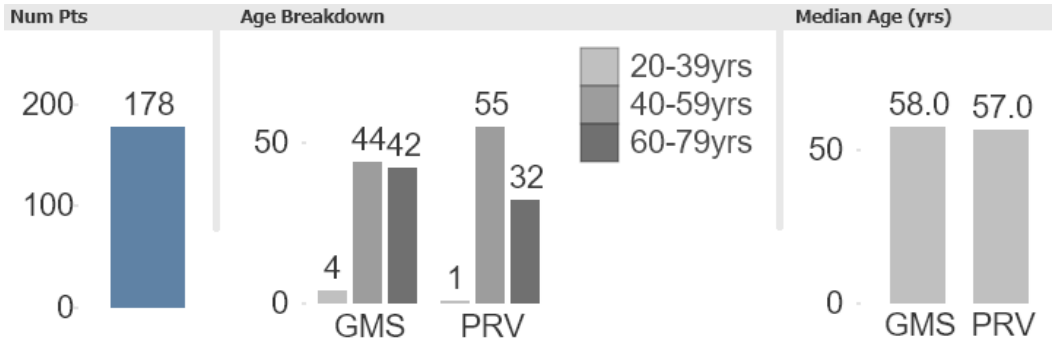

***Figure 1**- Age breakdown of cohort*

T2DM was the predominant condition in both groups (see Figure 2), with just 10 patients coded for heart failure. This reflects both the higher prevalence rates and coding of diabetes. As may be expected, there was some overlap, with 3 patients having both diabetes and heart failure.

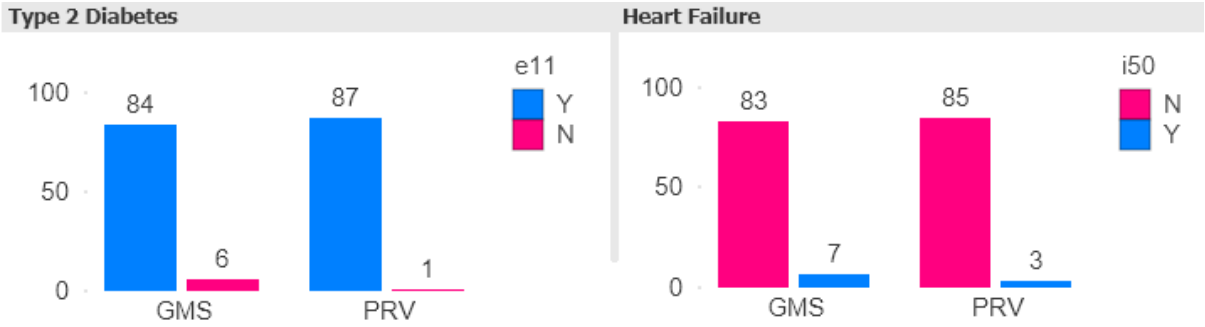

***Figure 2**- Conditions in GMS/DVC & PRV cohorts*

3.1 HbA1c Monitoring and Control (see Figure 1)

As shown in Figure 3, HbA1c was tested for almost all public patients. Of note, despite all but one of the private cohort having diabetes,13 of 88 private patients (15%) had no HbA1c test performed in 2024.

Regarding average number of HbA1c tests per patient in 2024, public patients had 2.0 tests/year/patient, whereas testing was 25% less common in the private cohort (with 1.5 tests/year/patient).

Median HbA1c for public patients was 50 mmol/mol, whereas median HbA1c for private patients was 52 mmol/mol.

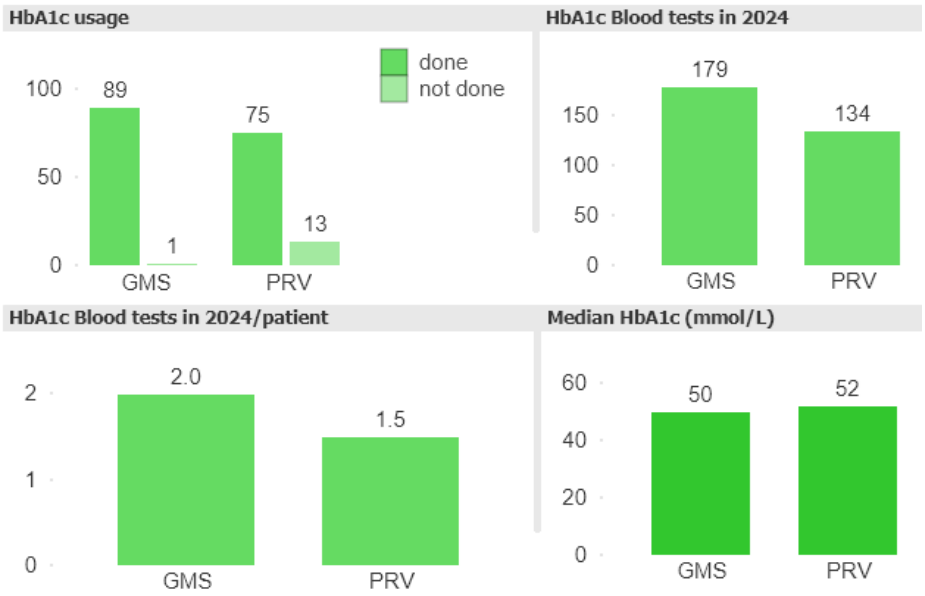

***Figure 3**- HbA1c parameters*

3.2 BNP Monitoring and Control (see Figure 4)

BNP testing was infrequently used in both groups, and as shown in Figure 4. A higher proportion of public patients were tested. Average rates of BNP usage meant 3 in 10 of the public cohort had a BNP/NTproBNP checked in 2024. Less than 1 in 10 of the private cohort had a BNP/NTproBNP checked in 2024.

Among those tested, 45% had abnormal results.

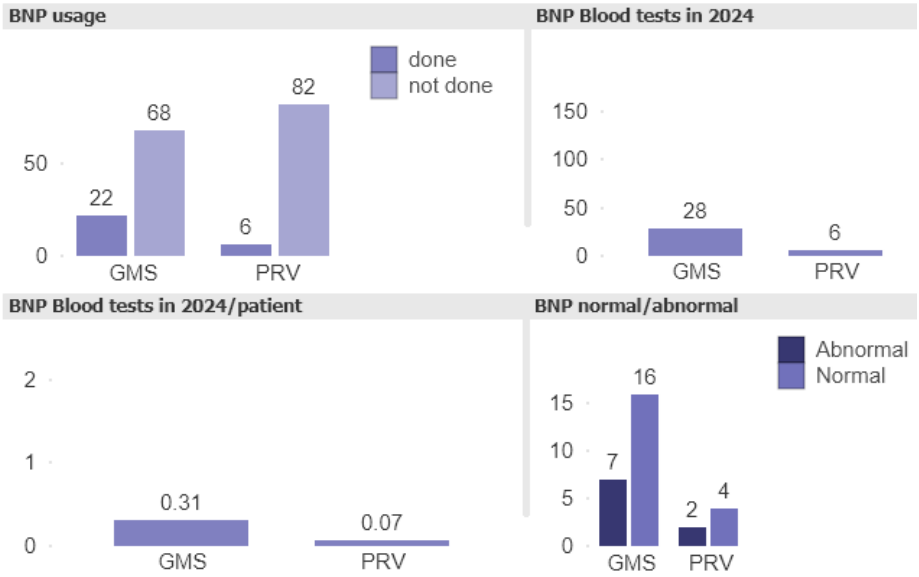

Figure 4 *– BNP parameter*

4. Discussion

This audit of care of 178 patients in Irish general practice provides evidence of a disparity in chronic disease monitoring between public and private patients. Public patients, likely enrolled in the CDM programme, received more regular HbA1c and BNP testing.

Although patients aged 18-69yrs typically qualify for public GP care due to chronic illness or low income- factors usually associated with worse health outcomes- their HbA1c results were better than those of private patients. This suggests that frequent monitoring and management via structured public care is having a positive impact.

Of concern, 15% of private patients did not receive an HbA1c test in the calendar year despite having a diagnosis of T2DM. This suggests potential gaps in structured chronic disease follow-up for patients outside of the public programmes.

The comparatively infrequent use of BNP testing likely reflects selective use of BNP, though findings of elevated BNP in almost half of those tested suggests this test is assisting GPs in 1) diagnosing HF, 2) recognising HF exacerbations and 3) fulfilling obligations for BNP/NT-proBNP testing at CDM registration.

5. Conclusion

This audit highlights a trend- public patients are more likely to receive regular chronic disease monitoring and show better outcomes. This may reflect the success of the CDM programme in delivering structured care to public patients.

There is an opportunity to consider how similar structured supports might be extended to private patients, particularly those with known chronic disease, to ensure equity of care across patient groups and deliver similar benefits for the wider health system.