ICGP Pre-Budget Submission 2024

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Introduction

The **Irish College of General Practitioners (ICGP)** is the professional body for general practice in Ireland. The ICGP is the representative organization for education, training, and standards in general practice and encourages the highest of standards. The College is the recognised body for the accreditation of specialist training in general practice in Ireland and is recognised by the Medical Council as the representative academic body for the specialty of general practice.

There are 4200 members and associates in the College comprising over 85% of practicing General Practitioners (GPs) in the Republic of Ireland. In addition, there are 1044 GP trainees working in general practice on a supervised basis and who are undertaking the ICGP four-year National GP Training Programme.

Since the commencement of the Non-EU Rural GP programme, at the beginning of this year there are now 75 GPs completing the two years scheme. This programme will have 100 doctors undertaking same by the end of 2023 and will add a further 200 in 2024.

The last three years have created very serious strain on general practice, affecting both patients and the GP community. Notwithstanding this, without general practice, the positive societal and health impacts resulting from the vaccination and boosters' programme would not have been possible. It is notable that 'routine' general practice continued, with routine childhood vaccines and cervical smear uptake unaffected by the pandemic.

The delivery of healthcare is changing rapidly, partially due to new technologies, and the pressures on hospitals. Most GPs have special clinical interests (dermatology, gynaecology, musculoskeletal medicine, nursing homes etc.) and many more want to develop sub-specialist expertise. In the future, the structure of General Practice will be built around a Primary Care Team approach i.e., GPs, nurses, a practice manager, and administrative staff, combined with allied health professionals.

General practices are coming under pressure to adapt to change, and they are flexible and open to change, and this has been very clear in the pandemic, where they were able to adapt their practices to ensure delivery of patient care.

However, there is a significant shortage of GPs to replace those retiring and to meet population demand. That is one of the key reasons the College is increasing our intake of GP Trainees to 350 in 2024, rather than waiting until 2026 as previously planned, and we have also introduced and established the Non-EU Rural GP Programme.

GPs and their Practice Teams are pivotal to societal wellbeing. GPs provide comprehensive whole person and continuity of care. The GP is most likely the first point of contact in matters of personal health; coordinates the care of patients and refers patients to other specialists; cares for patients of all ages and disease categories and cares for patients over a period of their lifetime. However, general practice is under serious strain.

GP practices are busier than ever, but less able to find replacements for retiring GPs, or new GPs to expand their practices and deal with growing workloads. Being a GP is the most wonderful professional career. However, we must resource, expand and be creative in our thinking to ensure we do not cease to be patient centred, and patient focused.

We are in the midst of a general practice workforce and workload crisis that is not going away. The COVID-19 pandemic has brought longstanding workforce and workload challenges to a head. This notwithstanding, the COVID-19 pandemic has demonstrated that general practitioners are flexible, adaptable, and able to embrace change.

The current GMS contract and HSE structures make it difficult for establishing general practitioners to set up. The capital costs of acquiring 'bricks and mortar' are substantial and a significant barrier to young GPs establishing practice. In an ever worsening economy and high interest rates, this situation is getting even worse. The challenge of becoming an employer of

many practice staff is a further barrier to young GPs establishing a practice. In addition, many rural practices and inner-city practices in deprived areas are being left unfilled when the GP retires, due to the inability to recruit mainly because of a general lack of supports and incentives from the HSE. GP-led practices are at the heart of their communities, with strong local connections, and patient centred care.

Several positives have emerged from the last three years, such as availability of diagnostics, telemedicine, better organisation of our waiting rooms, electronic prescriptions and eCertification, all of which have enabled greater efficiencies in general practice. However, that face-to-face engagement with our patients is the cornerstone of general practice, valued by our patients and we cannot lose that.

The last three years have been exhausting and we ensured that general practice remained delivering patient care despite many obstacles. However, we also have a responsibility to look after one another, our staff, and our own wellbeing and that of our families. The pace at present is not sustainable.

In July 2023, 286 new trainees (the highest number to date) were admitted into our training programme. There are now over 1000 trainees in total in the ICGP 4-year training programme.

The ICGP are now promoting their 2024 recruitment campaign which is looking to increase the intake of medical graduates to 350 GP trainee posts to lead out on the primary care needs for our community over the coming years. Increased training places will become available throughout the country.

Both manpower projections and population growth have spurred direct action from the HSE and Department of Health to facilitate ICGP in increasing available post-graduate training posts within Ireland in the coming years.

This represents an acknowledgement of the significant transfer of Chronic Disease Management from secondary hospital care to Primary General Practice care over the past number of years. It also reflects the expanded eligibility for free GP Care at point of contact.

This in turn provides a substantial response to the acknowledged difficulties patients have encountered in getting registered with local GPs in many cities, towns, and rural areas of the country. Maintaining patient access to a GP is and will continue to be central to ICGP's mission.

The College acknowledges and thanks the Minister of Health, HSE and Department of Health for working with the College to expand GP training and supporting our Non-EU Rural GP Programme. We are also encouraged by the recent establishment of the Strategic Task Force on the Future of General Practice. This has been an ask of the College for many years, and it is our view that it will play a very pivotal role in determining the future of general practice and improved access and patient care. The College looks forward to being proactively involved in the discussions and output of same.

What is General Practice care?

General practice is now seen as:[1]

- The patient's first point of contact with the health services. All else in the health service flows from that encounter.
- Person-centred.
- Comprehensive care from the beginning to the end of life.
- Coordinating care between the many agencies involved in the care of complex chronic illnesses.

In this context, general practice is key to:

- Timely equitable access to high quality care.
- Urgent and Acute care.
- Continuity of care.
- Local availability.
- Access to clinical knowledge and expertise.
- Generalist care.

General practice in Ireland provides professional quality care, at the heart of the local community. It is the cornerstone of the Irish health service. GPs are the first port of call for most patients.

On a normal day, a GP must deal with multiple issues presented by patients, from a depressed young adult to a new-born baby, to an elderly woman with several complex needs. General practices are not a generic group - they vary hugely between larger urban group practices in suburbs, to smaller rural practices, and practices in deprived areas, all with a high level of complexity. During the pandemic, GPs pivoted to telemedicine to ensure continuity of patient care.

General practices are under significant pressure. The population continues to increase with our population now at 5.1 million, an increase of 7.6% since 2016,[2] and people are living longer. However, there has not been a similar increase in the General Practice workforce to deal with the many increasing challenges. GPs are dealing with highly complex illnesses from a wider range of patients, under very challenging circumstances. GPs work on average almost 10 hours per day in practice.[3]

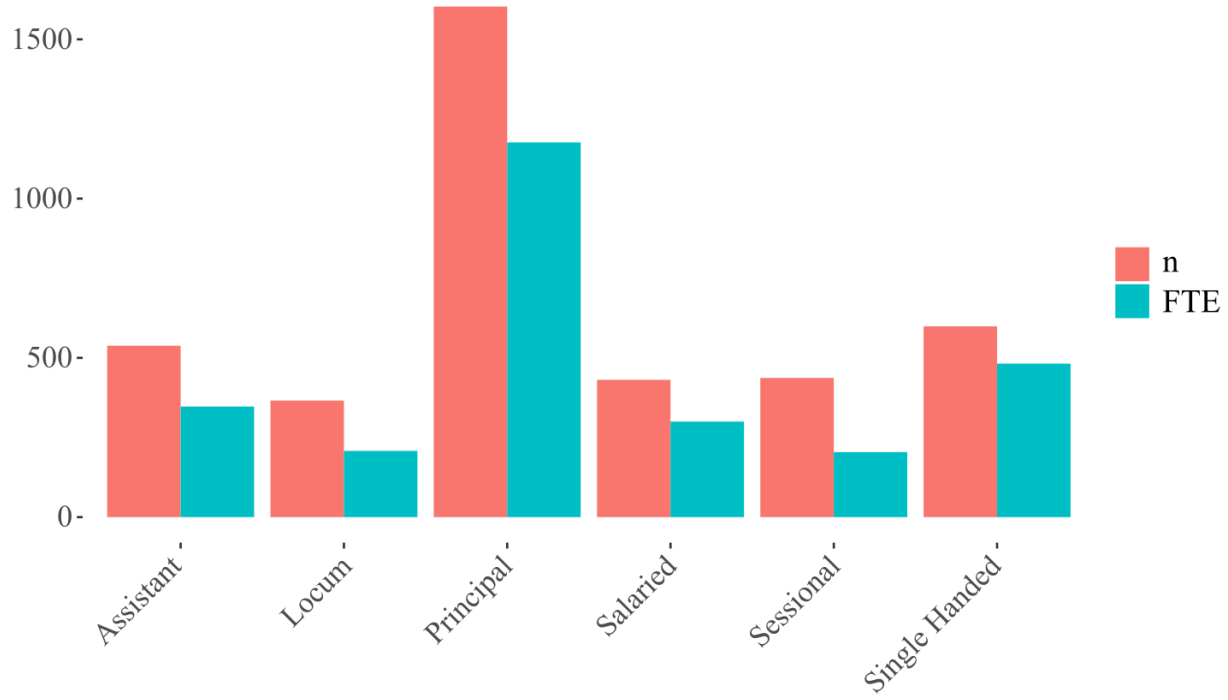
Looking at those working in general practice, 56% are female.[4] The proportion of females among all clinically active doctors on the medical register is 47%.[5] The average age of GPs in practice is 50.0 years.[4] This is higher than the average age of all clinically active doctors on the Medical Council register which is 44.2 years.[5] The average age of female GPs in practice is significantly lower than male GPs in practice, 46.9 years compared to 53.9 years respectively.[4] When we compare the GP number and Full Time Equivalents (FTEs) we see the greatest disparity is in the younger age groups indicating that more GPs in these age groups are working less than full time in clinical practice (many have other key roles e.g., teaching, research).[4]

Looking at those who are working (4,187 GPs) in general practice, 24% (989) are aged 60+ years and therefore due to retire within ten years, 14% (589) are aged 65+ years and are therefore due to retire within five years. However, it is notable that almost 5% (221) of those working in clinical practice currently are aged over 70 years.[4]

GP number and FTEs by age group

Among those working in clinical general practice, almost 14% report being single handed; and these GPs are least likely to be working part-time.[4]

GP number and FTEs by position



Overall, 45% of GPs are working <8 sessions per week in clinical general practice.[4] The normal GP working day is 10 hours on average.[6] A GP working week of eight clinical sessions is working 40 hours, excluding additional GP OOHs, and continuing professional development.[3] Two hours of clinical work generates one hour of administrative work.[3, 6]

Reducing one's clinical sessions may be a means of addressing quality of life issues[7] and may point to GPs engaging in careers which are not totally focused on clinical practice. However, the trend of decreased clinical sessions has consequences for a profession which has had a consistent short supply and will impact on replacement ratios. It has been forecast that a 37% rise in the primary care workforce is needed to meet demand.[8]

Recent work published by the ICGP calculated a total of 29 million consultations (GP and GPN) take place in general practice annually with GPs spending an average of 13.7 minutes per

consultation.[6] The same study estimated that Irish people visit their GP 4.34 times a year,[6] similar to data reported elsewhere. This increases to 5.91 general practice visits per person per year when both GP and GPN visits are included.[6]

Key Recommendations

1. GP Led multidisciplinary teams.

We need to further develop the multidisciplinary Primary Care teams (nurses, pharmacists, phlebotomists, healthcare assistants, etc.) within general practice. The HSE are developing the "Enhanced Community Care" initiative and it is hoped that this will incrementally support GPs and our patients in timely access to clinical expertise, diagnostics, and therapies. It is important that expansion in both areas is conducted simultaneously.

With increased urbanisation and the growth in the size of general practices, we need to recognize the importance of management and administrative support to enable GPs to do their work efficiently.

In that respect we need:

- GP Managers for bigger teams, with HR support.
- Group Practice consolidation.
- Practices that enable GPs to specialise and pursue a portfolio career.
- Greater role for nurses in general practice i.e., a rapid increase in Practice Nurses, advanced nurse practitioners, nurse prescribers etc.
- Increased use of phlebotomists, healthcare assistants and pharmacists.

These initiatives will rapidly liberate GP time to address patient complexity and multimorbidity.

In the context of Primary Care health assistants, the College welcomes the recent agreement between the IMO and the HSE.

The HSE needs to facilitate the support of:

- GP training in business planning and management.
- GP training in setting up and building group practices at community level.
- Where group practice is not viable or feasible, the HSE also need to facilitate the ongoing support of such practices, enhancing practice collaboration and networking.

The financial and planning resources needed to develop big practices is significant. The DOH/HSE must move away from seeing GPs solely as contracted providers to meaningful engagement with us as genuine partners in health care. If our vision is GPs as the leaders in delivering health in the community, we must engage and collaborate more. For example, the DOH could work with the European Investment Bank to set up a fund to provide low interest loans to groups of GPs to set up primary care centres run by those GPs. Not only could this fund work for larger practices but it could also be used to micro-fund small, even single-handed practices where there is an urgent need particularly in rural general practice and in inner city deprived areas. There is significant planning required at all levels for a substantial project like this alone.

2. The current number of approximately two thousand General Practice Nurses (GPNs) needs to be doubled at a minimum.

We need substantially more general practice nurses, with resourcing and supports comparable to secondary care nurses. The ICGP and our colleagues in the Irish General Practice Nurses Educational Association (IGPNEA) have recently initiated engagement with our universities to deliver high-quality education to train general practice nurses. We also very much welcome the start

of the Graduate Diploma in Primary Care Nursing Practice in University College Dublin. This is very positive.

General practice nurses are skilled autonomous clinicians with a broad clinical expertise. The ICGP has long advocated for a substantial increase in the number of GPNs.[9-11] As it stands there are approximately 2000 GPNs in Ireland[12] making up about 45% of clinicians in general practice. Both their practices and the GPNs themselves have embraced enhanced roles but have legitimate concerns about the training, funding, and indemnity for such development.[13]

A recent Canadian systematic review of the impact of nurses in primary care concluded that they have a role in medication management, patient triage, chronic disease management, sexual health, routine preventative care, health promotion/education, and self-management interventions (e.g., smoking cessation support).[14]

GPNs are central to the vision GPs have for the development of general practice. There is the potential for career development for GPNs as some will want to become advanced nurse practitioners, nurse prescribers, or clinical nurse specialists to support chronic disease management and triage minor illness. To achieve this requires investment, training, and support.[14] To allow GPNs to practice to their highest levels, it is important that tasks that they currently do are devolved to another member of the team. Taking bloods, ECGs, spirometry, fitting 24-hour blood pressure monitors can all be done by a practice technician/phlebotomist. This presents an opportunity for a 'quick win' at relatively modest cost. Similarly, for GPNs, there are insufficient courses available to train suitable candidates.

In the context of GPNs, the College welcomes the recent agreement between the IMO and the HSE. However, still more needs to be done to attract greater numbers into this speciality.

3. Suitable premises need to be provided for GPs and their teams.

As GP-led primary care develops further, the demand for suitable premises will increase. Imaginative arrangements with leases and ownership need to be explored and delivered.

The built infrastructure is increasingly perceived as an unwanted, unnecessary, and unwarranted liability by potential GPs. Society does not require other healthcare workers to provide the work premises. The 'bricks and mortar' is now a barrier to recruitment, retention, mobility, and retirement. This is especially the case in affluent urban areas where property and rents are unaffordable for young GPs. The Scottish government and NHS Scotland have addressed this challenge, to incrementally reduce the built infrastructure risk burden on GPs.[15] Ireland urgently needs multiple innovative approaches to GP built infrastructure.

The HSE can support younger GPs establish practice by providing purpose-built GP premises, thereby avoiding substantial capital expenditure on 'bricks and mortar'. This 'built infrastructure' approach will support young establishing GPs, support relocation of overseas GPs to Ireland, and the amalgamation of smaller GP practices. This may include a variety of options, including interest free loans, HSE provided and HSE leased premises.

Expansion of the GP healthcare team, especially nurses, will require substantially more clinical space. Incentives to support an expanded GP team must address the built infrastructure requirements.

4. Resourcing Rural General Practice to attract GPs.

There is growing concern, particularly in rural Ireland, at the continued decline in GPs working in small communities. Newly trained GPs do not find rural practice attractive – and yet there are patients who require a GP in these areas. Therefore, innovative ways must be resourced to attract GPs to replace those GPs rapidly approaching retirement. These include consolidation of smaller practices in rural areas, satellite practices, built infrastructure, rural practice supports and

incentives and where appropriate, and with appropriate controls in place, the use of video consultations.

The College welcomes the support it is receiving with the Non-EU GP Programme as most of those who come through this system will be placed in Rural Areas. However, to ensure they stay and long-term sustainability, other supports as mentioned above will need to be put in place.

5. Access to Mental Health Services.

GPs manage the majority of mental health complaints in the Irish state, such as addiction, anxiety, and depression. There is a severe shortage of primary care psychological services in particular; this is curtailing effective management of these mental health conditions. We are beyond crisis point at this stage. It is critical and must be a budgetary priority that additional resources are applied to general practices to enable sessional psychological and counselling services to be financed. The ICGP recommends an increase in the number of allied primary care professionals, including psychologists, community psychiatric nurses and mental health therapists.

In this respect we welcome the funding provided by the HSE to appoint a GP Clinical Lead in Mental Health and who is now in post over 12 months. This is a positive sign. However, the level of frustration expressed by GPs in their inability to provide the appropriate care for highly vulnerable patients is a damning indictment on Irish society. Appropriate and tailored funding for mental health can wait no longer. The challenges around timely equitable access to a well-resourced CAMHS are well documented. Mental Health supports must be given prioritisation in this year's budget.

6. Information Communication Technology (ICT).

In March 2020, the implementation of electronic prescriptions has illustrated for the patient, GP and Pharmacist, the positive impact of good use of technology and innovation. The advancement of IT

solutions, such as summary care records, facilitated with a unique patient identifier, to enable an efficient integrated healthcare system, needs to be prioritized.

Investment in ecommunication solutions between GP and hospital care can improve patient safety, optimise referral rates and overall support secondary care. We urge that progress on implementation of many of the key IT recommendations referenced over many years are fast tracked.

6.1 Electronic Hospital Discharges: A standardized approach to electronic hospital discharges on a nationwide basis is required. This is available in some locations but is very limited. There is an excellent HIQA template for discharges. We recommend that hospital e-discharges are delivered using Healthmail (which is a secure email source). Such a change would dramatically improve patient care and lead to many efficiencies both within hospitals and the community. That there is no standardized national approach to electronic hospital discharges, reflects very poorly on Irish Healthcare.

6.2 ePrescribing: The use of Healthmail to send prescriptions to pharmacies was never intended to be a long-term solution. The introduction of a functioning ePrescribing system which is safe, secure, and compatible across all areas of patient care needs to remain an urgent priority.

7. To encourage more graduates to enter the specialty of general practice, medical schools need to increase the exposure time to general practice within the medical curriculum.

Not enough graduates of Irish medical schools select general practice as a career, leaving our long-term workforce planning in a highly vulnerable position. We need to adopt strategies similar to many other countries which have robustly engaged with the medical schools and successfully increased student selection of general practice careers.

We must build a diverse and inclusive workforce that is representative of the communities we wish to serve, underpinned by the principles of social accountability while being committed to gender equality and social inclusion and social justice.

Building on established international examples, and rigorous research evidence, we recommend focusing existing undergraduate medical programmes to producing graduates who select a career in general practice. The Scottish government "SCOTGem"[16] model is one exemplar.

The length and quality of general practice experience at medical school is accepted as a key positive factor in promoting general practice as a career.[17] Exposure to general practice as part of the formal, informal, and hidden curriculum, positive experiences and role models in general practice have all been identified as contribution factors in young doctors choosing to undertake higher education in general practice.[18,19]

The international literature is very clear that resourcing longitudinal placements in general practice is a key and essential first step in the GP workforce 'Pipeline'.[20] This should include a curriculum consisting of a minimum of 25% of GP placements. The recently opened Ulster University provides 30% of all teaching in general practice, commencing in the first week of medical school.

Ireland with the notable exception of the University of Limerick at 25%, has very limited exposure to clinical general practice. To increase the general practice curricular footprint to international norms, will require increased funding to support both general practice placements and general practice university academic staff. An anomaly currently exists where the terms and conditions of clinical academic general practice staff are not the same as those of other equivalent clinical staff in other university disciplines. This is a key deterrent to both attracting and retaining senior academic general practice staff who will be essential to lead and support such radical curricular change.

A specific rural curriculum and pathway should exist within undergraduate medical education and GP training. Rural students and GP trainers /mentors should be recruited and retained with exposure to rural practice maximised. This will also support the development of hospital physicians who wish to practice in rural regions.

GP Intern places need to be sufficiently expanded and resourced to continue the 'Pipeline' into postgraduate GP training. To meet the expansion of training across all specialities and to meet the chronic shortage of doctors both in every area of healthcare delivery, we need a radical overhaul of numbers entering undergraduate and graduate medicine. In addition, on completion of GP training, an average number of postgraduate general practice academic fellowships, with some dedicated to rural practice, needs to be established. These fellowships, funded by the National Doctors Training and Planning (NDTP) and the Health Service Executive (HSE) should form another step in this general practice career 'pipeline'.[19,20]

Conclusion

Irish general practice is changing rapidly and has changed beyond recognition in the last three years. General practice has also shown how flexible and adaptable it is to meet urgent needs. However, there are huge pressures on existing GP practices, and general practice must be supported and resourced to retain existing doctors and recruit new GPs into practice. At the moment, general practice is working efficiently, flexibly in a patient-centred way, based in the heart of the community, but is at breaking point. Over the next two decades, huge changes are coming, and the Department of Health, Sláintecare, HSE and ICGP must intensively collaborate to develop a policy that protects and grows general practice in the interest of patient care. We have seen progress through collaboration and engagement, and it is important this continues and is fast tracked.

We Need:

- Facilitate and fund the development of GP Led Multidisciplinary Teams.
- Increase the number of General Practice Nurses.
- Provide suitable premises for GPs and their teams.
- Resource Rural General Practice to attract GPs.
- Enable greater access to Mental Health Services as a matter of urgency.
- Investment in ICT, e.g., Electronic Hospital Discharges.
- Invest in Undergraduate Medical Education to increase the exposure time to general practice.

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