The Provision and Use of Health Services, Health Inequalities and Health and Social Gain

Brian Nolan (ed.)
Brenda Gannon, Richard Layte, Pat McGregor, David Madden, Anne Nolan, Ciaran O'Neill, Samantha Smith

1. THE FINANCING AND DELIVERY OF GP SERVICES IN IRELAND

Anne Nolan

The Economic and Social Research Institute, Dublin

1.1 Introduction

In this chapter we provide some details on the organisation and delivery of general practitioner (GP) services in Ireland. We begin by describing the structure of eligibility for free GP (and other public health services) in Ireland, before discussing the current organisation of the GP service in terms of the role of the GP; qualifications and entry requirements; practice characteristics; income sources; and relationship with the pharmacy and secondary care sectors. Finally, we compare the operation of the GP service in Ireland with those of other developed countries. The following chapter, Chapter 2, deals in more detail with the economics of GP services utilisation in Ireland, concentrating on the incentives faced by both providers and patients. Chapters 3, 4 and 5 analyse patterns of GP visiting in Ireland, the factors influencing variation in GP visiting rates across the population and in particular the role of incentives facing both providers and patients.

1.2 Eligibility for Free Public Health Services

1.2.1 ELIGIBILITY CATEGORIES

There are two categories of eligibility to public health services in Ireland: Category I or full eligibility and Category II or limited eligibility. All individuals who are ordinarily resident in Ireland have either full or limited eligibility for public health services. Individuals with full eligibility, termed 'medical card' patients, are those who are *…unable, without undue hardship, to arrange general practitioner, medical and surgical services for themselves and their dependents and all persons aged 70 years and over* (General Medical Services Payments Board[1], 2005). In 2004, 28.4 per cent of the population were eligible for a medical card

[1] As part of the large-scale reform of the organisational structure of the Irish health services in January 2005, the General Medical Services Payments Board was

(General Medical Services Payments Board, 2005), and were entitled to all public health services free of charge. The remainder of the population ('private' patients) are granted limited eligibility and are entitled to limited free public health services. Table 1.1 sets out the various free public health services that each category of eligibility is entitled to receive.

Table 1.1: Eligibility for Free Public Health Services in Ireland[2]

Category I (Medical Card Patients)

- GP services
- prescribed drugs and medicines
- dental, ophthalmic and aural services
- maternity and infant care services
- out-patient public hospital services
- in-patient public hospital services
- medical appliances
- community care services (e.g., public health nursing service, physiotherapy etc.)

Category II (Private Patients)

- public maternity and infant care services
- in-patient public hospital services (subject to a €65 charge per day)
- out-patient public hospital services (subject to a €65 charge per day)
- assistance towards the cost of prescribed medicines over a monthly limit (Drugs Payment Scheme)[3]
- assistance towards the cost of prescribed medicines for certain chronic conditions (Long-Term Illness Scheme) or high cost treatments (High-Tech Drugs Scheme)[4]

While private patients are entitled to free public hospital services and prescription medicines over a monthly limit, they must in general pay in full for all GP, dental, ophthalmic and aural services. Private patients are entitled to tax relief on certain medical expenses at their marginal rate of tax (they must, however, pay the first €125 per annum) and many are also eligible for reduced prices for certain dental and ophthalmic treatments under the Treatment Benefit Scheme administered by the Department of Social and Family Affairs, provided they have the necessary PRSI (social insurance) contributions. In addition, the three main private insurers (VHI,

renamed the Primary Care Reimbursement Service, and is now part of the Shared Services Directive of the Health Service Executive.

[2] See also www.oasis.gov.ie/health/

[3] Under the Drugs Payment Scheme (DPS), an individual or family only has to pay a maximum of €85 per month for all prescribed drugs, medicines or appliances for use by that person or a member of the family for that month.

[4] Under the Long-Term Illness (LTI) Scheme, individuals who suffer from certain conditions such as a mental handicap, epilepsy and cystic fibrosis and who are not already medical card patients may obtain, without charge, the drugs, medicines and surgical appliances for the treatment of that condition. Under the High-Tech Drugs (HTD) Scheme, individuals in need of high cost pharmaceuticals (e.g. anti-rejection drugs in the case of transplant patients) receive free pharmaceuticals. Individuals must register with their local Health Service Executive (HSE) Area in order to participate in these schemes.

BUPA and VIVAS) have recently introduced new plans that provide limited cover for primary care expenses (see Section 1.2.5 below). The Irish healthcare system has, therefore, a mixture of a universal public health service and a fee-based private system.

1.2.2 ELIGIBILITY CRITERIA

While the majority of those who are granted a medical card qualify on the basis of an income means test, individuals may also qualify on the basis of age, particular health needs and participation in approved Government training and employment schemes. From 1 July 2001, all individuals aged 70 years and over were granted automatic eligibility for a medical card, regardless of income. The income thresholds for a medical card are set nationally and updated annually by the Health Service Executive (HSE). The intention is that the decision to seek medical care should not be dependent on economic resources/ability to pay. Each individual must apply to their local Health Service Executive Area (of which there are currently ten) for a medical card. Currently (as at 31 December 2006), the (gross) weekly income thresholds are €184.00 for a single person living alone, €266.50 for a married couple and €342.50 for a married couple with two children. The limits increase for those aged 66 years and over (e.g. for a married couple the limit increases to €298.00). To put the thresholds in context, the average gross weekly industrial wage in Ireland in June 2006 was €602.35 (Central Statistics Office, 2006). The medical card covers the individual and their dependents, except where the individual is 70 years or older. For example, for a married couple in which one partner is aged 68 years and the other 71 years, the 71 year old is automatically entitled to a medical card but the 68 year old will only be entitled to a medical card if the income of the couple falls below the income threshold for a married couple aged 66-69 years.

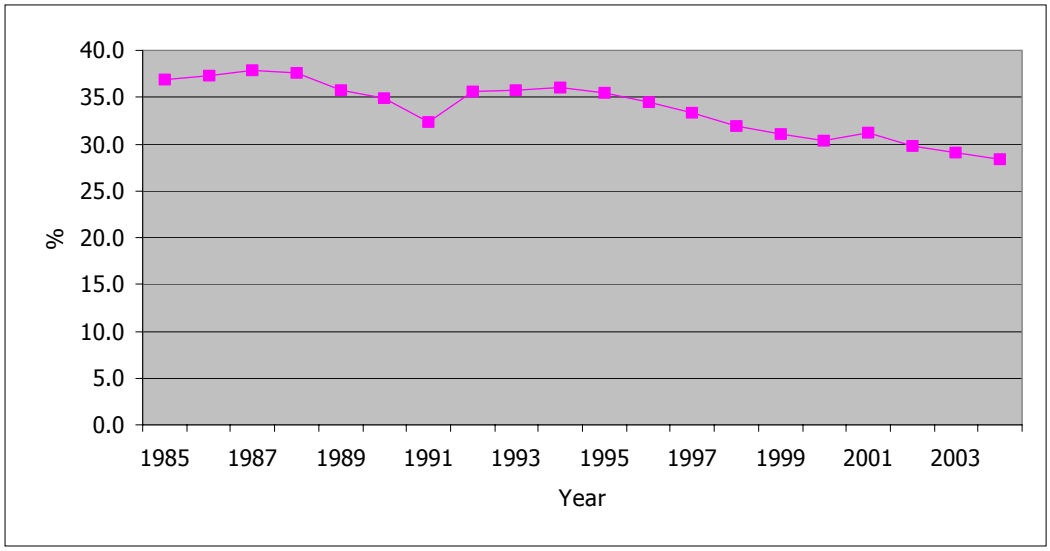
Individuals whose only source of income is from various social welfare programmes (e.g. old age non-contributory pension, disability allowance, unemployment assistance) are also automatically entitled to a medical card. Individuals who previously held a medical card but who participate in various Government approved training and employment schemes (designed to encourage the long-term employed and economically inactive to enter into employment) are allowed to retain their medical card for a period following their entry onto these schemes (the maximum period is four years). Finally, individuals whose income is above the threshold for a medical card but who are faced with particular hardship (e.g., high medical expenses) may be granted a medical card (Comhairle, 2004). However, there are no clear guidelines governing the granting of such 'discretionary' medical cards and consequently, there is no information available on the proportion of medical card patients granted a card on grounds other than income (Comhairle, 2004). A recent report highlighted this confusion, noting that the Department of Health and Children estimated the number of discretionary medical cards at 20,000 in 2001 (1.6 per cent of the total medical

card population in that year) but 75,000 in 2002 (approximately 6.4 per cent of the total medical card population in that year), while the HSE estimate that the number of discretionary medical cards is likely to be between 65,000 and 68,000 and the number currently recorded on the Primary Care Reimbursement Service database is 36,000 (Comptroller and Auditor General, 2006).

1.2.3 TRENDS IN MEDICAL CARD COVER

While the income thresholds for a medical card have increased in line with inflation since 1995, the income guidelines have lagged considerably behind the growth in average incomes. Combined with increasing employment over the period since 1990, this has meant that while medical card coverage stayed relatively stable at approximately 38 per cent of the population over the late 1980s, it fell steadily throughout the 1990s and early 2000s to reach 28.4 per cent of the population in 2004. There was a slight increase from 2000 to 2001 with the extension of eligibility to all those over 70 years in July 2001 but coverage has since fallen back again (see Figure 1.1).

Figure 1.1: Medical Card Cover, 1985-2004



Sources: General Medical Services Payments Board, various issues.

1.2.4 ADDITIONAL ELIGIBILITY CATEGORIES

There are a number of additional schemes that provide free GP services to certain population groups. For example, individuals who contracted Hepatitis C through the use of contaminated blood products administered by the State in the 1970s are entitled to a Health Amendment card. This entitles the holder to free GP services, but the GP does not have to enter into a contract with the HSE to provide such services. In addition, the Maternity and Infant Care scheme provides limited free GP care to all mothers during pregnancy and to all mothers and children for a short period following birth.

In October 2005, a new 'doctor-only' medical card was introduced, the GP Visit card. The income limits are 50 per cent higher than for a standard medical card (e.g., for a single individual aged 66 years or younger, the weekly income threshold is €276.00). However, eligible individuals receive free GP consultations only (i.e., they must pay for their own prescription medicines). This followed much commentary that highlighted the significant difficulties faced by those just above the threshold for a medical card in affording GP services and prescription medicines (see Section 4.3.1 for further analysis of this issue). While the government has suggested that an additional 200,000 individuals are now eligible for free GP visits under the GP Visit card scheme, by December 2006 only 25 per cent of the available cards had been taken up (*The Irish Times*, 12 December, 2006).

1.2.5 PRIVATE HEALTH INSURANCE

Many of those without medical cards purchase private health insurance. Private health insurance in Ireland covers the full or partial cost of treatment and care services provided in private hospitals and by medical consultants in private beds in public hospitals but in general does not cover the cost of GP services, prescribed medicines or dental, ophthalmic and aural services unless a large deductible is reached. However, in recent years, the three main insurers have introduced additional plans that provide limited cover for some of the cost of a GP visit.[5] Tax relief at source (at the standard rate of tax, i.e., 20 per cent) is available for private health insurance premiums. A small proportion of the population (2.1 per cent in 2001) hold both a medical card and private health insurance, probably to ensure speed of access to hospital care as these

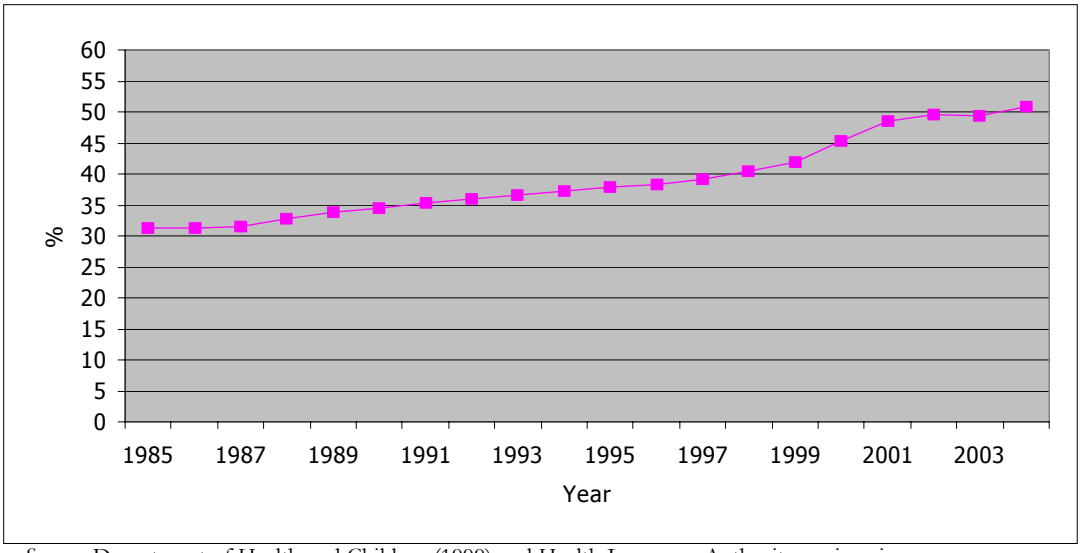
[5] Under some health insurance plans, part of the cost of GP services is reimbursed once a large deductible has been exceeded. In addition, the three main health insurers have recently introduced partial coverage for GP expenses, either as a fixed refund per consultation (e.g., €20 under some VHI plans) or as a percentage of the cost (e.g., 50 per cent under some BUPA plans). Despite the extension of private medical insurance to partial coverage of GP expenses, a 2003 survey found that only 9 per cent of individuals had private insurance that partly covered the cost of GP consultations (National General Practice Information Technology Group, 2003).

individuals are on average older and suffer from various health conditions in greater proportions than those without such 'dual' coverage (Central Statistics Office, 2002).

1.2.6 TRENDS IN PRIVATE HEALTH INSURANCE COVER

The proportion of the population covered by private health insurance has increased steadily since 1985, to reach a point where just over half the population are covered (see Figure 1.2). This is despite increases in premiums in excess of inflation over the period, the reduction in tax relief on private health insurance premiums from the marginal to the standard rate of tax in 1994 and the extension of free public hospital care to the entire population in 1991 (prior to 1991 there was an additional category of eligibility, i.e., those in the top 15 per cent of the income distribution who had to pay for the costs of their treatment in a public hospital).

Figure 1.2: Private Health Insurance Cover, 1985-2004



Sources: Department of Health and Children (1999) and Health Insurance Authority, various issues.

1.3 Delivery of GP Services

1.3.1 THE ROLE OF THE GP

GPs are independent professionals who provide a variety of diagnostic services and medical treatments in a community setting. *Medical practitioners diagnose physical and mental illnesses, disorders and injuries, and prescribe medications and treatment to promote or restore general health* (Indecon Economic Consultants, 2003, p. 325). GPs also provide certain additional services such as immunisation; family planning; insurance and pre-employment medicals; and minor surgery. With the exception of accident and emergency (A&E) visits, GPs are the individual's first point of contact with the health services, with GPs acting as gatekeepers for access to secondary care services in Ireland.

1.3.2 ENTRY REQUIREMENTS

To practice as a GP in Ireland, individuals must gain entry to a university medical school (TCD, UCD, UCC, NUIG and RCSI), and undertake a minimum of six years study, and then complete a 12-month internship in hospital. Upon completion of their internship, the individual is eligible to apply for registration on the General Register of Medical Practitioners. The Medical Council (the regulatory body for the medical profession in Ireland) maintains the General Register of Medical Practitioners and the Register of Medical Specialists. All EU-trained doctors are eligible to practice in Ireland, and there are reciprocity agreements in place between Ireland and Australia, New Zealand and South Africa, which allow doctors to transfer to practice in Ireland. For individuals who trained in non-EU countries, the Medical Council must authenticate the individual's qualification, and in addition, the individual must sit further examinations in clinical and language studies (Indecon Economic Consultants, 2003).

Of the 15,600 individuals who are currently registered on the General Register, the Medical Council estimates that approximately 11,000 are practising (Office of the Revenue Commissioners, 2005). Indecon Economic Consultants estimate that of the 8,952 practising medical practitioners in 2001, 2,691 or 30.1 per cent were GPs, with consultants, non-consultant hospital doctors and others (e.g. doctors in academic posts, public health medicine etc.) accounting for 23.1 per cent, 39.6 per cent and 23.1 per cent respectively. A recent survey by O'Dowd *et al.* (2006) estimated that there were 2,477 GPs in Ireland in 2005, a 28 per cent increase over the 1,937 estimated for 1992.

1.3.3 SUPPLY OF GPs, AND PRACTICE CHARACTERISTICS

In 2003, there were an estimated 2,700 GPs practising in Ireland (Indecon Economic Consultants, 2003), which is equivalent to approximately 0.7 GPs per 1,000 population. The corresponding average for thirteen EU countries in 2002 was 1.0 GP per 1,000 population (OECD, 2005). Table 1.2 shows the results from a 2003 survey of over 1,000 GPs. It highlights that about a third[6] of GPs operated as solo practices (in many cases from a surgery attached to their own home), nearly half employed a practice nurse and nearly two-thirds had one or more administrative staff. On the other hand, only 6 per cent of practices employed an additional health professional such as a physiotherapist, counsellor or social worker. The same survey also found that that 67 per cent of GPs were male, 13 per cent were aged 26-35 years, 29 per cent were aged 36-45

[6] The corresponding figure from a 1988 survey for over 100 GPs was 59 per cent.

years, 37 per cent were aged 46-55 years, 18 per cent were aged 56-65 years and 3 per cent aged 66+ years.[7]

Table 1.2: GP Practice Characteristics, 2003 (Percentages)

	GP	Practice Nurse	Practice Manager	Administrator	Other Professional
None*	3	34	72	10	89
One	32	46	28**	33	6
Two	29	15		27	3
Three or more	36	5		30	2

Source: National General Practice Information Technology Group (2003).[8]
* also includes not stated.
** includes 0.4 per cent who had two or more.

A 1996 survey of GPs found that 72.4 per cent of GP practices found it either "extremely difficult" or "very difficult" to recruit GPs over the last three years; 23.5 per cent found it "difficult" and only 4.1 per cent reported that they had no difficulty in recruiting GPs. *The difficulties prevailing in relation to recruitment may reflect restrictions on the supply of doctors in Ireland, including in relation to the number of medical graduates from the schools of medicine* (Indecon Economic Consultants, 2003, p. 359). In addition, there are concerns over the supply of GPs in certain areas based on claims that medical card lists are increasingly difficult to allocate in rural and certain deprived urban areas (FÁS, 2005).

1.3.4 GENERAL MEDICAL SERVICES (GMS) SCHEME

GPs may enter into a contract with the HSE to provide services to medical card patients (under the GMS scheme), in addition to services provided to private patients. A 2003 survey of GPs found that 84 per cent held GMS contracts (National General Practice Information Technology Group, 2003), while a 2005 survey found that 96 per cent of GP practices had a GMS list, leaving just 4 per cent engaged only in private practice, in comparison with 91 per cent and 9 per cent respectively in 1992 (O'Dowd *et al.*, 2006). The operation of the GMS scheme is such that an individual GP is generally permitted to have a maximum of 2,000 GMS patients (Indecon Economic Consultants, 2003). In addition, GPs also provide services to certain population sub-groups covered under State schemes such as the Maternity and Infant Care Scheme, the Primary Childhood Immunisation Scheme and the Methadone Treatment Scheme. Even GPs who do not hold a GMS list are likely

[7] A more recent survey of over 500 GPs in 2005 finds broadly similar results (O'Dowd *et al.*, 2006).
[8] A 1996 ICGP survey found that 42 per cent of GP practices were single-handed; 28 per cent were comprised of two GPs; 15 per cent were comprised of three GPs and 14 per cent were comprised of four or more GPs. The average number of doctors per practice remained constant at around 1.7 between 1999 and 2001 (Indecon Economic Consultants, 2003).

to provide services under the latter schemes. Individual GPs acquire a GMS list through one of three channels:

- By national competition for an advertised GMS list in a defined area for a vacancy arising or a post created.
- By national competition to post of assistant with a view to partnership with an established GMS contract holder principal.
- Under special regulations introduced in 1999 that permit the right of application for a GMS contract, conditional on the doctor having been engaged in full-time general practice for a specified period of time (Indecon Economic Consultants, 2003).

Medical card patients register with a GP of their choice from a list of GPs who participate in the GMS scheme. Under the terms of the GMS contract, a GP cannot discriminate between public and private patients in terms of the quality and quantity of treatment. The organisation of this system ensures that public and private patients receive the same standard of care, a situation that did not exist prior to the establishment of the GMS scheme in 1972. The introduction of the GMS (or 'choice-of-doctor') scheme in 1972 allayed concerns at the time that public and private patients received differential treatment from their GPs. Under the previous system, private patients attended the private surgery of the doctor of their choice while public patients were required to attend the surgery of the nominated 'dispensing' doctor in their area (Hensey, 1979).

The current contractual commitment to public patients is for 40 hours per week on five days or more. Suitable arrangements must also be made to enable contact to be made with him/her or his/her locum/deputy outside normal hours for urgent cases. In general a GP with a GMS contract is expected to accept all eligible patients on to his/her list when so requested, provided the individual lives within seven miles of the surgery. The latter does not apply where there is no participating GP within seven miles of the patient.[9]

1.3.5 SOURCES OF GP INCOME

GP income comes from three main sources: private fees, State schemes (primarily the GMS scheme) and other fees (such as locum or rota fees where GPs are obliged to provide an out-of-hours service for their locality, fees from the provision of medical reports for insurance purposes or court cases and from clinical testing).[10] Individual GPs set their own private fees. Neither the Medical

[9] However, where the GP does not wish to accept a particular patient(s), the HSE may request that a confidential explanation be provided by the GP explaining his/her reasons. At any time after the inclusion of a patient on a GP's list, the GP may request the HSE to remove the patient from his/her panel. The GP may be requested to provide, in confidence, reasons for the request. The HSE may assign an eligible patient to a GP where the patient has been unsuccessful in applying to all medical practitioners in an area or to at least three of them, whichever is less. Where a GP has a patient assigned to him/her the assignment will be reviewed after six months has lapsed (Irish Medical Organisation, 2002).

[10] See also Office of the Revenue Commissioners (2005).

Council nor the Irish Medical Organisation (the trade union which represents GP interests) has any influence over the fees charged. Table 1.3 sets out recent estimates of the average cost of a standard GP consultation, which range from €33 to €36. The Revenue Commissioners report noted that higher rates are charged for out-of-hours consultations and for non-standard procedures (e.g. vaccinations) while repeat and family visits may be charged a reduced rate (Office of the Revenue Commissioners, 2005).

Table 1.3: Average GP Private Fees (€)

	Indecon (2003)	GPIT (2003)	Revenue (2005)
Average	33	36	
Median	33		
Minimum			35
Maximum			50
Standard Deviation	5		
Home Visit	42		

Source: Indecon Economic Consultants (2003); National General Practice Information Technology Group (2003); Office of the Revenue Commissioners (2005).

The Indecon survey also sought the views of the general public, the major health insurance companies and medical practitioners themselves on the extent of price competition among medical practitioners in Ireland (remembering that this refers to medical practitioners more broadly rather than GPs). Of the general public 59 per cent felt that there was "virtually no" or "very little" price competition among medical practitioners in Ireland, with only 18 per cent believing that there was "significant" price competition. Not surprisingly, medical practitioners were more positive about the perceived levels of price competition in the market, although only 18 per cent still believed that there was "significant" price competition among medical practitioners in Ireland.[11]

In terms of government sources of GP income, the largest proportion of income from government sources is from the GMS. Additional State funding comes from the Maternity and Infant Care Scheme; the Primary Childhood Immunisation Scheme; the Health Amendment Act (1996) Scheme; the Methadone Treatment Scheme; the Indicative Drug Targeting Scheme (see Section 1.3.7) and from various government departments for the provision of certain services (e.g., medical examinations in suspected drink driving cases for the Department of Justice, Equality and Law Reform). In 2006, government expenditure on the GMS scheme (including GP and pharmacy fees, cost of medication etc.) accounted for 13.6 per cent of total government expenditure on health, an increase from 12.8 per cent in 2005 (Department of Finance, 2006).[12]

[11] See Table 9.19 in Indecon Economic Consultants (2003).

[12] However, expenditure on the hospitals programme still accounts for the majority of expenditure on health in Ireland, accounting for 39.7 per cent in 2006 (and 40.3 per cent in 2005) (Department of Finance, 2006).

The Primary Care Reimbursement Service (previously the General Medical Services Payments Board) undertakes the reimbursement of providers for GP, dental, optical and pharmaceutical services supplied to patients under the GMS scheme as well as the reimbursement of pharmacists for services provided to non-GMS patients under the various drugs schemes (DPS, LTI and HTD Schemes). At present, GPs providing services to medical card patients (i.e., participating in the GMS scheme) are reimbursed on a capitation basis.[13] This payment is weighted for the age, sex and distance from the doctor's surgery of the patient, and is paid monthly. There are some additional fee-for-service payments for procedures such as suturing and for out-of-hours consultations. In 2004, 66.5 per cent of all fees paid to GPs participating in the GMS scheme were capitation-derived, with fees for out-of-hours services and special services (e.g., influenza vaccine) accounting for the next largest proportions (10.7 per cent and 9.9 per cent of total fees respectively) (General Medical Services Payments Board, 2005). GPs are not obliged to provide certain services free of charge to medical card patients (e.g., eye tests for driving license applications or medical examinations for life assurance). Prior to 1989, GPs were also remunerated on a fee-for-service basis for their public patients. However, in part as a result of evidence presented by Tussing (1985) in favour of demand inducement by GPs under a fee-for-service system, this system was changed to capitation in 1989 (see also Section 2.4.2).

Capitation-based payments mean that the risk of overuse is borne by the provider, but on the other hand, the provider benefits from infrequent consultation by their patients. From the government's point of view, a capitation system is attractive in that expenditure is known in advance. However, there are concerns that a capitation payment system encourages providers to maximise the size of their patient list, but to avoid registering certain high usage groups such as the elderly or those with chronic illnesses; to spend as little time as possible with patients; to discourage repeat visits; and to refer patients to secondary care or other practitioners as soon as possible. With fee-for-service reimbursement on the other hand, providers are given an incentive to encourage repeat visits, to carry out expensive treatments and to retain the patient rather than referring to secondary care. However, for the government or financier there is considerable uncertainty with exact levels of expenditure only know retrospectively (Society of Actuaries in Ireland, 2000).

[13] However, 18 GPs are still reimbursed under a fee-for-service arrangement, which was the arrangement that existed prior to the change to capitation in 1989 (Office of the Revenue Commissioners, 2005).

1.3.6 GP WORKLOAD

A 1988/1989 survey of 119 GPs found that the average GP had a practice of 1,818 patients, and 43 per cent of these were GMS patients. Interestingly, there was little or no relationship between GMS and private list size; those with small GMS lists did not correspondingly have large private practice lists, and those with large GMS lists were just as likely to have large private lists as small. Doctors saw an average of 150 patients per week, which equates to 4.5 consultations per person per annum (with GMS consultations at 6.2 per annum and private consultations at 3.2). The average duration of a consultation was twelve minutes. 57 per cent of repeat consultations were initiated by the patient. The survey found no relationship between the number of repeat consultations and the practice list size. Of all consultations 86 per cent took place in the surgery, and 11 per cent in the patient's home. Excluding consultations described as being for repeat prescriptions, the prescribing rate was 63 per cent for GMS patients and 49 per cent for private patients (Irish College of General Practitioners, 1992). In 2005, approximately two-thirds of GMS lists contained under 1,000 patients, and only 5 per cent contained 2,000 patients or more. In contrast, approximately 26 per cent of practices had fewer than 1,000 private patients, with approximately 40 per cent having 2,000 private patients or more (O'Dowd *et al.*, 2006).

1.3.7 RELATIONSHIP WITH PHARMACIES

The majority of GPs do not undertake dispensing duties; a network of privately owned and operated pharmacies provides this service. Pharmacists who dispense medicines to public patients are reimbursed by the Primary Care Reimbursement Service on the basis of the ingredient cost plus a flat-rate dispensing fee. Private patients pay out-of-pocket for prescribed medicines but are assisted with the cost of prescribed medicines by the State via the DPS, LTI and HTD Schemes. Claims under these schemes are also processed and paid for by the Primary Care Reimbursement Service (but reimbursed as ingredient cost plus 50 per cent mark-up).[14]

[14] The recent Department of Health and Children (2003) report on financial management and control of the health service recommends that the procedure for reimbursing pharmacists under the GMS scheme be extended to that for the other drugs schemes (DPS, LTI and HTD) to remove the incentive for GPs to prescribe more expensive drugs to private patients, thereby increasing the profit margins of pharmacies.

There has been much discussion about the escalating costs of prescribing by GPs.[15] In 1993, the Indicative Drug Targeting Scheme (IDTS), which is also administered by the Primary Care Reimbursement Service, was established in an attempt to make GPs more aware of the costs of their prescribing decisions.[16] Each GP is set a prescribing target (in money terms), which is adjusted for the age and gender of their medical card patients. GPs who prescribe less than this target are allowed to invest 50 per cent of their savings in practice development, e.g. upgrading or replacing equipment. Before the introduction of the scheme, a GP's revenue was not affected by the amount or the cost of the drugs they prescribed with the result that they had no financial incentive to reduce this cost. However, questions have been raised regarding whether the IDTS causes a deterioration in the quality of treatment for public patients. It has been shown that the IDTS has had a negative effect on prescribing patterns of new drugs to GMS patients, compared to private patients, which reversed the pattern that existed prior to the establishment of the scheme (Durkan, 2002). GPs are given an incentive to prescribe fewer drugs and to prescribe cheaper drugs for their medical card patients. While the immediate cost savings are apparent, this type of action could potentially increase the long-term cost to the State of treating the person, for example through secondary care. In addition, the scheme is voluntary; GPs retain the right to prescribe as they see fit and there are no sanctions in place for those who fail to meet their target (Comptroller and Auditor General, 1997).

[15] Over the period 1990-2002, the cost of prescribed medicines under the GMS scheme increased by 177.5 per cent in real terms (General Medical Services Payments Board, various issues). Tilson *et al.*, 2002 states that in addition to such factors as an ageing population, the early diagnosis of chronic illness with subsequent early introduction of long-term drug therapy and the increased expectations of patients regarding the range of treatments and quality of services available to them, the two main drivers of increasing expenditure on medicines include the product mix, i.e., prescribing of newer more expensive medications and the volume effect, i.e., the prescribing of a greater number of medicines for patients. They subsequently found that 11 of the top 30 drugs, of highest cost to the GMS scheme, had a generic equivalent, which, if substituted, could produce savings in the region of €5.65 million per annum.

[16] Durkan (2002) describes the background to the establishment of the IDTS. A review of the GMS by the Department of Health and the Irish Medical Organisation was carried out in 1990/1991, against a backdrop of very significant increases in the cost of prescribing in the previous four years. This increase was attributed to increased use of more expensive drugs and an increased volume of drugs, rather than price increases, as prices tend to be frozen for established prescription drugs. As a consequence of this review, the IDTS was established on 1 January, 1993. A review group was established in 2003 to further review the operation of the system, as it is felt that the current calculation of targets based on age and sex is too simplistic and that some allowance for medical need of patients is necessary (Department of Health and Children, 2005).

1.3.8 RELATIONSHIP WITH SECONDARY CARE

GPs act as gatekeepers for secondary care in Ireland, and with the exception of attendance at A&E departments, are the first point of contact with the health services for the majority of individuals. There are two main sources of admission to hospital as an in-patient: as an emergency case through A&E, or as an elective case referred by a GP or another hospital doctor for specialised treatment. In 2001, 48 per cent of in-patient admissions to St. James's Hospital in Dublin were from A&E, 30 per cent were elective admissions and 16 per cent were emergency admissions from the out-patient department (see www.stjames.ie). There is much discussion that many A&E attendances would be more appropriately dealt with in a primary care setting. The cost of attending an A&E department without a letter of referral from a GP is now greater than the average cost of a GP consultation, removing the previous incentive to use the A&E service in preference to a GP visit. However, the lack of a comprehensive out-of-hours GP service in certain areas may still mean that for many, an A&E visit is their only option.

The financing of primary and secondary care in Ireland encourages a shift away from primary care towards more expensive secondary care services, and is …*exactly the opposite of the way an efficient financing system would work* (Society of Actuaries in Ireland, 2000). For medical card patients, the incentive to refer the patient to secondary care rests with the GP, who is paid a capitation payment for each medical card patient. For private patients (with and without insurance), the incentive to seek treatment in a secondary rather than a primary care setting rests with the patient who must pay out-of-pocket for GP care, but receives free or heavily subsidised public hospital care (and in the case of those with private medical insurance, faster access to hospital).

1.4 Comparative Perspective

1.4.1 ELIGIBILITY FOR FREE GP SERVICES

Despite their focus on general practice as the cornerstone of the health system, most European countries differ considerably in the major characteristics of primary/GP care such as employment levels, eligibility criteria for free GP services; method of payment; gate-keeping function; practice organisation etc. and the patterns of use and incentive structures that result from these underlying institutional arrangements. Table 1.4 summarises some of the main characteristics of the system of general practice in a selection of developed OECD countries. The majority of developed OECD countries provide universal access to free or heavily subsidised GP services. As in Ireland, the Netherlands, New Zealand and USA only provides free GP care to certain population groups such as those

Table 1.4: GP System Characteristics in EU-15 and Australia, Canada, New Zealand, Norway and USA

COUNTRY	Exceptions to Eligibility for Free or Heavily Subsidised GP Services	Patient Contribution to GP Services	GP Reimbursement	Gatekeeper Role for GP
Australia		Co-insurance (where GP engages in 'balance-billing', otherwise none)	Mixed, mainly fee-for-service	Yes
Austria		Co-insurance	Mixed	Yes
Belgium	'Minor Risks' for Self-Employed	Co-insurance	Fee-for-service	No
Canada		No	Fee-for-service	Yes
Denmark	2 per cent who reserve the right to choose their GP (group II)	Balance-billing for group II	Mixed	Yes, for majority (98 per cent)
Finland		Co-payment	Mixed	Yes
France		Co-insurance	Fee-for-Service	No
Germany	High income earners who decide to opt-out of State health insurance scheme (private: 10 per cent)	No	Mixed (public) Fee-for-service (private)	No
Greece		No	Salary	No
Ireland	70 per cent above an income threshold (non-medical card)	No (medical card) Full cost (non-medical card)	Mixed, mainly capitation (medical card) Fee-for-service (non-medical card)	Yes
Italy		No	Capitation	Yes
Luxembourg		Co-insurance	Fee-for-service	No
Netherlands	Normal medical risks such as GP visits for individuals above an income threshold (private: 40 per cent)		Capitation (public) Fee-for-service (private)	Yes
New Zealand	Those above an income threshold (non-community service card)	Co-payment (community service card) Full cost (non-community service card)	Mixed	Yes
Norway		Co-payment	Salary for majority who hold State contracts; remainder are paid fee-for-service	Yes
Portugal		Co-payment	Salary	Yes
Spain	High income self-employed and civil servants who decide to opt out of State scheme	None	Salary	Yes
Sweden		Co-payment	Mixed	No
UK		None	Mixed	Yes
USA	Those who do not quality for Medicare (elderly) and Medicaid (low income and disabled)	Co-insurance for private patients with private insurance, otherwise full cost	Mainly fee-for-service	No

Sources: Bindman and Majeed (2003); Commonwealth Department of Health and Aged Care (1999a), (1999b), (2002); Dixon and Mossialos (2002); European Commission (2002); *European Observatory on Health Care Systems*, various issues; European Union of General Practitioners (2003); Green (2004); Jepson (2001); Ministry of Health (2001); Mossialos *et al.* (2002); Oxley *et al.* (1994); Van Doorslaer *et al.* (2002).

Co-insurance refers to a fixed percentage of the total cost of a consultation whereas co-payment refers to a flat fee.
Mixed refers to a mixture of reimbursement methods: salary, capitation, fee-for-service and allowances. Most rely on a sub-set (e.g. Australia relies mainly on fee-for-service with some allowances, Spain relies on salary and capitation and the UK relies on capitation, fee-for-service and allowances).

with incomes below a certain threshold, the older population or young children. Even when individuals are entitled to cover for GP services under State schemes, certain population groups may be subject to co-payments (a fixed fee) or co-insurance (a fixed percentage) on the cost of a GP visit. In order to ensure that intensive users of health services or those on low incomes are not discouraged from seeking care, many countries exclude certain categories from co-payments or co-insurance (e.g., children and old-age pensioners in Austria) or impose an annual ceiling (e.g., Finland, Norway and Sweden). Ireland, the Netherlands, New Zealand and the USA have a similar distinction between different sections of the population (based on economic status) but are unusual in the substantial proportions of the population that must pay the full fee-for-service each time they visit their GP. The principal rational behind user charges is to reduce unnecessary or excessive use of services. However, it is felt that user charges may deter necessary as well as unnecessary treatments. A key issue is the extent to which the deterring of necessary treatments impacts on the future consumption of services and long-run health status (OECD, 1987).

While the main reason for taking out private medical insurance in Ireland is to ensure speed of access to hospital and to guard against large hospital bills (Harmon and Nolan, 2001), in many European countries, private insurance is taken out to assist in costs associated with out-patient care such as GP services. For example, in the Netherlands, the 40 per cent of the population ineligible for free GP and other out-patient services are expected to take out private medical insurance to cover such costs while in Austria, Belgium and France, many private insurance plans cover co-insurance for GP visits (i.e., complementary cover).

1.4.2 THE ROLE OF THE GP

In the majority of countries, GPs are independent operators, as in Ireland. However, in Finland and Sweden, the majority of GPs are employees of the local county council or community, meaning that integration with other primary care services is consequently much stronger than in countries where GPs are organised as independent operators. As discussed above, the potential role for the primary care sector in controlling access to more expensive secondary care is well recognised. Amongst EU countries, Austria, Denmark, Finland, Ireland, Italy, the Netherlands, Norway, Portugal, Spain and the UK require a referral from a GP before visiting a hospital specialist (except in emergency cases) while the residents of Belgium, France, Germany, Greece, Luxembourg and Sweden are free to consult a specialist without a referral from a GP (see Table 1.4).

1.4.3 SUPPLY OF GPS

In comparison with the other countries of the old EU-15, Ireland has a relatively small supply of GPs per 1,000 population (see Table 1.5). At the other end of the scale are countries such as France and

Finland who have 1.64 and 1.66 GPs per 1,000 population respectively.

Table 1.5: Number of GPs per 1,000 Population (EU-15), 2003

COUNTRY	2003
Austria	1.42
Belgium	1.35
Denmark	0.71
Finland	1.66
France	1.64
Germany	1.04
Greece	
Ireland	*0.59*
Italy	0.95
Luxembourg	0.89
Netherlands	0.51
Portugal	0.56
Spain	
Sweden	0.56
United Kingdom	0.65

Source: WHO Regional Office for Europe (2006).
Data for Belgium refer to 2001 and for Sweden to 2002.

1.4.4 GP REIMBURSEMENT

Much recent attention has focused on the extent to which the incentive structures underlying the reimbursement of GPs lead to an equitable and efficient distribution of resources, both between different sectors of the population and between different levels of care (see also Section 2.3.3). Pure fee-for-service reimbursement systems exist in a number of OECD countries such as Belgium, Canada and Luxembourg (see also Table 1.4). However, there are concerns that such systems encourage GPs to engage in "demand inducement" (see Tussing, 1985). Capitation payments, where GPs are paid a fixed amount per patient, usually adjusted for age, sex and other relevant factors, remove the incentive to arrange unnecessary return visits but may encourage the GP to discourage necessary as well as unnecessary return visits, to shorten consultation periods and to refer patients to secondary care as early as possible. Many countries (Australia, Austria, Denmark, Finland, Germany, Ireland, New Zealand, Sweden and the UK) combine the various methods of payment by using a mixture of salary, capitation payments, fee-for-service payments for 'extra' services such as suturing or vaccinations and allowances for extra expenses such as a practice nurse. In some countries, different categories of individual imply a different reimbursement system (as in Ireland). For example, in Germany, the majority of the population (90 per cent) receive free GP services and GPs are reimbursed by a mixture of fee-for-service, capitation and salary for these patients, while the remaining 10 per cent on high incomes pay a fee-for-service to their GP (which is subsequently reimbursed by private insurance).

1.4.5 GP VISITING RATES

In terms of variation in the number of doctors' consultations across the OECD, Table 1.6 indicates that the number of doctors' visits per capita in 2001 varied from a low of 2.9 in Sweden to a high of 9.0 in the USA. Due to difficulties in making accurate comparisons across different countries using OECD data, which suffer from differences in definitions, data sources etc. (see notes to Table 1.4), data from the European Community Household Panel (ECHP), which includes health data for twelve European countries from 1994 to 2001 inclusive, based on a standardised questionnaire, are also presented in Table 1.6. Unlike OECD data, doctors' consultations are differentiated into visits to GPs, specialists, dentists etc. (from 1995 onwards). They indicate much more similarities in GP consultations across Europe with countries such as Germany and Italy with (near) universal access to free GP consultations having a higher average number of GP consultations than Ireland and The Netherlands, where certain sectors of the population must pay out-of-pocket for GP consultations. These data also indicate the possible influence that institutional arrangements have on the utilisation of GP services. For example, Italy, with a gatekeeping role for GPs and no user charges, has a high average number of GP consultations per annum while Sweden, similarly with no gatekeeping role but with some user charges, has a much smaller number of GP consultations per annum.

Table 1.6: Average Number of Visits to the Doctor and GP Per Annum (EU-15 and Australia, Canada, New Zealand, Norway and USA), 2001

	Doctor	GP
Australia	6.4	
Austria	6.7	4.7
Belgium	7.8	4.8
Canada	6.2	
Denmark	7.0	3.0
Finland	4.3	2.1
France	6.9	
Germany	7.3*	
Greece	2.5*	1.9
Ireland		3.5
Italy	6.1	4.6
Luxembourg	6.2	
Netherlands	5.8	2.8
New Zealand	4.4	
Norway		
Portugal	3.6	2.9
Spain	8.7	4.1
Sweden	2.9	
UK	4.9	3.2
USA	9.0	

Sources: OECD (2005); European Community Household Panel Survey (2001).
*Data for doctors' consultations for Germany refer to 2000 and for Greece to 1998.

1.5 Summary and Conclusions

This chapter began by detailing the current structure of eligibility for free GP services in Ireland, distinguishing between those with full eligibility (medical card patients) who receive free GP services and prescription medicines and those with limited eligibility (private patients) who must pay in full for all GP services and receive free prescription medicines above a monthly deductible. The organisation of GP services reflects to a large part this distinction, particularly in terms of GP reimbursement where GPs receive a capitation payment for their medical card patients and a fee-for-service from their private patients. This combination of eligibility structure and reimbursement system obviously impacts on the incentives faced by both patients and GPs in terms of GP care, and this issue will be returned to in more depth in the next chapter.

The chapter also detailed the current organisation of GP services in Ireland, focusing on entry criteria and qualifications; practice characteristics; income sources; workload and relationship with the pharmacy and secondary care services. GPs act as gatekeepers in Ireland and as such, are the first point of contact with the health services for the majority of individuals. The GP service, therefore, has a crucial role in reducing reliance on more costly secondary care services and to this end, it is important to ensure that the GP service is properly equipped, staffed and incentivised to treat patients in this setting in the first instance. We also revisit this issue in the following chapter. Finally, this chapter provided a brief overview of the operation of the GP service in other developed OECD countries. While Ireland shares many characteristics with other countries, Ireland is largely unique in the extent to which only a minority of the population are entitled to free GP services. The next chapter will analyse in more detail the economics of GP services utilisation, in particular the structure of incentives, from both a patient and provider perspective, while the following chapters review the empirical evidence on GP and patient behaviour in the Irish setting.