

Competition in Professional Services

general medical practitioners

The Competition Authority is undertaking a study across a range of eight professions in the construction, legal and medical sectors of the Irish economy. The specific professions being reviewed are engineers, architects, dentists, optometrists, veterinary surgeons, medical practitioners, solicitors and barristers.

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The Competition Authority
An tÚdarás Iomairíochta

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EXECUTIVE SUMMARY

Key findings

The Competition Authority has identified three factors that are having an impact on competition in GP services in Ireland:

1. Restrictions on the number of qualifying GPs;
2. Restrictions on advertising by GPs; and,
3. Restrictions on GPs wishing to treat public patients.

These restrictions are contributing to difficulties being experienced by patients - in terms of accessing regular GP services in certain “blackspot” areas of the country and rising prices for private patients.

The cost of visiting a GP has risen rapidly in recent years, significantly outpacing the general rate of inflation in the economy. There are indications that a substantial number of private patients are delaying GP visits due to cost factors and are “shopping around” for cheaper consultation fees. The State paid an average of €65 for every GP visit made by a public patient in 2008.

In examining these issues, and engaging with those with the power to make reforms, the Competition Authority has identified solutions to improve the supply of qualified GPs and facilitate informative advertising by GPs, and their implementation has already been progressed. Training more GPs and allowing them to advertise will have a limited impact on competition however, unless those GPs are able to get a General Medical Services (“GMS”) contract.

A GMS contract is very valuable to a GP practice; very few GP practices operate without one. The current GMS system favours existing GP practices and protects them from competition from newly qualified GPs.

The restrictions on competition arising out of the GMS system affect both private patients and public patients.

- Both public and private patients have fewer GP practices to choose from, and
- There is less pressure on GP practices to compete on price for private patients and to be innovative in the service they provide.

The impact of the GMS on private patients is often overlooked. It is assumed that “the market” will take care of them. This ignores the fact that the market for private patients is itself significantly affected by the operation of the GMS. The GMS system impacts directly on the commercial behaviour of almost every GP practice in the State, affecting decisions on where GPs locate, the number of GP practices established, the nature of such practices and the profitability of individual practices. This in turn affects the provision of services for private patients and indirectly influences the price GPs charge private patients.

An adequate number of GPs for Ireland

There are an estimated 2,800 doctors working as GPs in Ireland. This number is relatively low by international standards. Ireland has only 60% of the number of GPs per thousand population compared to Germany or the US, and only about two-thirds the number of most continental European countries.

The increased feminisation of the GP profession in recent decades has been accompanied by a rise in part-time working, among both male and female GPs, and a movement towards earlier retirement. As a result, an increased number of GPs will be required in the future simply to maintain existing levels of service provision.

These factors, as well as rising demand, raise concerns about the adequacy of the supply of GPs in Ireland now and into the future. These concerns are particularly significant given that Government health policy aims to increase the focus of healthcare on primary care, moving treatment away from hospitals into the community. An adequate supply of GPs is essential to such a strategy and also to competition in GP services.

The path to becoming a GP in Ireland is much more structured than in the past. Doctors must now undertake four years of specialist training in general practice before qualifying as a GP. As a result, the number of new GPs qualifying in Ireland is dependent on the number of specialist GP training posts available, in a way that was not the case in the past. The number of doctors being trained as GPs will need to rise substantially in the years ahead as a result of all these changes in the GP profession and to cater for predicted population growth.

In examining the training of GPs in Ireland, the Competition Authority identified an issue that has historically impeded the number of GPs qualifying in Ireland each year. Currently all training programmes for GPs require that all trainees complete four years of training: 2 years of hospital-based training with some off-site training ("Phase 1") and 2 years of GP practice-based training ("Phase 2"). GP trainees receive a salary from the Health Service Executive ("HSE") during each year of their training. No recognition or flexibility is granted where a trainee has previously obtained equivalent relevant hospital-based training. Doctors with previous training who obtain a place on a GP training course must often repeat training they have already completed.

The Competition Authority met the Irish College of General Practitioners ("ICGP") in 2008 and argued that the requirement to repeat training was costly, inefficient and ultimately was limiting the number of new GPs available to treat patients in Ireland. We proposed that an alternative intensive course – a "*Phase 2 Orientation Programme*" – could be introduced as a fast-track option for doctors who have completed relevant hospital-based training. It would allow doctors with prior relevant hospital-based training to proceed directly to the in-practice phase of GP training. This Programme would be equivalent to the off-site component of Phase 1 of GP training and provide doctors with appropriate knowledge and orientation for general practice. This proposal was deemed to be a workable solution by the ICGP.

There is general agreement that the recognition of prior relevant training would remove a bottleneck in the number of qualified GPs Ireland can produce each year. Implementing the Competition Authority's fast-track system for training GPs would help alleviate predicted shortages in the number of GPs in Ireland, in an efficient and cost-effective manner. The issue of the funding of additional Phase 2 GP trainee places is a matter under discussion between the HSE and the ICGP.

Restrictions on advertising

In 2007, the Competition Authority identified significant unnecessary restrictions on advertising by GPs and the supply of information to patients. For example, medical practitioners who were setting up practice could only announce their presence by way of newspaper notices. Local radio announcements, flyers and other normal methods of creating awareness of a new business were not allowed. Advertising of prices was actively discouraged. These restrictions were contained within the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Professionals*.

When the Medical Council started a review of the Guide in 2007, the Competition Authority made a detailed submission to the Council. The submission highlighted that the restrictions went beyond what was required to protect the public from misleading advertising, and instead had a number of negative effects such as discouraging price competition and limiting the knowledge consumers had about GP services in their area. We recommended that restrictions on the content, place and size of practice signs and advertisements be removed, along with the restrictions on distributing price information.

The Medical Council subsequently removed the restrictions from the Council's updated ethical guidelines *Guide to Professional Conduct and Ethics for Registered Medical Professionals* (7th Edition) published in November 2009.

The removal of the restrictions on advertising will make it easier for consumers to obtain information about the availability and price of GP services in their area. It will also bring benefits to newly established GPs who want to advertise their new practices and should encourage GPs to offer new and innovative ways of delivering their service now that they can fully inform the public of their services.

GMS system restricts competition between GP practices

Competition between GP practices is restricted by certain features of the GMS system¹.

The GMS system favours existing GP practices and protects them from competition from newly-qualified GPs. It reduces the number of GP practices available to patients, by creating unnecessary barriers to entry.

Changes in the GMS contract cannot take place without the agreement of the Irish Medical Organisation ("IMO"), a representative body for GPs. This includes agreement on payments made to GPs under the GMS. Such collective negotiations by "undertakings"² on fees are prohibited by Section 4 of the Competition Act 2002 ("the Act") and by Article 101 of the Treaty on the Functioning of the European Union ("TFEU").

The prohibition on collective negotiations is there to protect consumers and the State from concerted practices by independent businesses which could result in them (ie. consumers and/or the State) paying higher prices than necessary for their purchases. In the current instance, its purpose is to protect the State from paying excess prices for GP services purchased by the HSE.

¹ The GMS system ensures GP services are provided free-of-charge to 1.6 million "public patients" e.g. medical card holders throughout the State.

² An "undertaking" is defined in section 3 of the Act as meaning "a person being an individual, a body corporate or an unincorporated body of persons engaged for gain in the supply of goods or the provision of a service".

Recommended changes to the GMS

The Competition Authority is recommending a number of changes to the GMS system so that patients (public and private) and the State reap the full benefits of competition between GP practices. The recommendations are addressed to the Minister for Health and Children, the HSE and the IMO.

First, all qualified GPs should be entitled to obtain a GMS contract, subject only to meeting general suitability criteria. Currently, GMS contracts are only awarded in circumstances where a list of public patients becomes available through the death, resignation or retirement of an existing contract-holder, or where the HSE (following consultation with the IMO) identifies a need for a new GMS post.

Second, the GMS contract should not be tied to a specific location. Contracted GPs should be entitled to set up in practice in, or move to, the location of their choice.

Third, decisions by the HSE to award new GMS contracts and decisions on the allocation of public patient lists following the death, retirement or resignation of an existing contract-holder should not favour GPs who already hold a GMS contract. At the moment it does this in two ways: (i) by failing to award a contract in cases where the HSE (after consulting the IMO) feels that the “viability” of existing GP practices in an area would be threatened by a new entrant; and (ii) by treating GPs who hold a GMS contract more favourably in the interview marking scheme for GMS posts.

Fourth, decisions about the fees and allowances to be paid to GPs under the GMS contract should be made unilaterally by the Minister for Health and Children, following (if desired) consultation with GPs and/or the IMO.

Implementation of these recommendations is complicated by the fact that the GMS contract (which is between the HSE and individual GPs) is contingent upon an agreement (or series of agreements) between the Minister for Health and Children and the IMO. Any change in the GMS contract requires first that the IMO agreement be amended; this amendment must then be reflected in the GMS contract. What this means in practice is that, in order for our recommendations to be implemented, the IMO must agree to their implementation. The existence of this contractual relationship has been one of the key impediments to reform of the GMS. It may ultimately prove easier and more effective to terminate the existing contract and start afresh with a clean slate rather than seek to amend the existing contract.

Recommendations

This report makes seven recommendations for change. Five of these relate to changes in the GMS system; the remaining recommendations relate to GP training programmes and advertising by GPs.

A. The removal of practices which protect established GMS-contracted GP practices from competition from newly-qualified GPs.

Recommendation 1: Access to GMS Contracts should be opened up to all qualified and vocationally trained GPs, who meet general suitability criteria.

Recommendation 2: GPs in possession of a GMS contract should be free to set up in, or move to, the location of their choice.

Recommendation 3: Decisions to award a GMS contract in a particular area should not be required to take account of the “viability” of existing GP practices in that area.

Recommendation 4: The marking system for awarding GMS contracts should be amended to ensure that applicants with similar levels of GP experience are awarded equal points and that applicants already in possession of a GMS contract are not treated more favourably.

B. Changes in the process for determining payments to GPs under the GMS.

Recommendation 5: Payments to GPs under the GMS should be decided, not on the basis of agreement with the IMO, but unilaterally by the Minister for Health and Children, following (if desired) consultation with GPs and/or the IMO.

C. Changes relating to the training of GPs.

Recommendation 6: A fast-track GP training programme (“*Phase 2 Orientation Programme*”) should be introduced for doctors who have completed relevant hospital-based training.

D. Changes relating to advertising by GPs.

Recommendation 7: Unnecessary restrictions on advertising by GPs should be removed. **(Implemented 2009)**

The Authority's recommendations on advertising by GPs were incorporated in new guidelines for medical practitioners issued by the Medical Council in 2009. GPs are now allowed to advertise their services (including the prices charged), as long as the information provided is "*factually accurate, evidence-based and not misleading*".³ This opens the way for more informed patient choice and may help to promote more price competition for private patients.

Our recommendation to introduce a fast-track GP training system for doctors who have already completed relevant hospital training and experience, thus preventing them from having to repeat certain elements of their training, has not yet been implemented. The number of places on GP training programmes was increased from 120 to 157 in 2010, in order to boost the supply of GPs. However none of the additional training places have been allocated to "Phase 2" trainees.⁴ We will continue to seek the implementation of our recommendations in this area.

³ Medical Council, 2009, *A Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (7th Edition), page 49.

⁴ "Phase 2" trainees are doctors who have already acquired relevant hospital training and experience. If these doctors subsequently enrol on a GP training programme, current regulations oblige them to repeat elements of their hospital-based training.

1. INTRODUCTION

“The issue for policy makers ... is not whether markets are good or bad, but... whether fostering some aspects of competition and markets in the health sector can lead to more rational use of resources, and which aspects of competition have the greatest potential to get results.” OECD (2009), Achieving better value in healthcare.

- 1.1 The Competition Authority aims to ensure that competition works well for consumers and the Irish economy. One of the Competition Authority’s functions under Section 30 of the Competition Act 2002 is to “*study and analyse any practice or method of competition affecting the supply and distribution of goods or the provision of services or any other matter relating to competition*”.
- 1.2 This Report is part of a wider study of a number of professions. Previous professions studied were: engineers, architects, dentists, optometrists, veterinary practitioners, solicitors and barristers.
- 1.3 The Competition Authority decided to focus its study of the medical profession solely on primary medical care services provided by General Practitioners (“GPs”). The main reasons for this decision are as follows:
 - GPs are typically the first point of contact for medical practitioner services and are the most common contact for the public;
 - People are much more aware of, and knowledgeable about, the service they expect and need from primary care providers than from secondary care providers. They are therefore in a better position to make informed decisions about the primary healthcare services they require;⁵
 - Medical practitioners in primary care compete for customers (both publicly funded and private fee paying) in a manner akin to those professions examined in previous reports; and
 - The issues surrounding negotiations between consultants and private health insurance (“PHI”) companies, and competition between PHI companies (which can drive competition between private hospitals and between medical practitioners), have already been addressed by the Competition Authority.⁶
- 1.4 Healthcare is often seen as lying outside the scope of competition policy because most of the issues that arise, such as the equitable allocation of resources and finance, are seen as questions of social and health policy rather than competition policy. It is not the role of competition policy to replace health policy and it is not the role of the Competition Authority to identify the appropriate level or allocation of State funding for health services. The ultimate responsibility for health policy rests with the Government and, in particular, the Minister for Health and Children. The contribution of the Competition Authority is to analyse, within any given set of health policy and funding parameters:
 - The role of competition in the cost and availability of services for patients; and
 - The implications for taxpayers, in terms of value for money.

⁵ In this Report the terms patients, consumers and customers are used interchangeably and refer to individuals seeking the services of GPs.

⁶ See *Medical Fees Guidance Note* at <http://www.tca.ie/templates/index.aspx?pageid=1074> and *Competition in the Private Health Insurance Market* at <http://www.tca.ie/templates/index.aspx?pageid=1090>

Competition among GPs

- 1.5 Competition among General Medical Practitioners (“GPs”) in Ireland is constrained by a shortage of GPs at national level.⁷ The essence of competition is choice. Competition cannot operate effectively if there are not enough GPs to offer patients a choice of GP in all areas. The first essential step in any strategy to increase competition among GPs must therefore be to ensure an adequate supply of GPs.
- 1.6 Competition among GPs in Ireland has traditionally been muted further by a combination of regulatory restrictions (which prohibited, until recently, price advertising for private patients) and professional norms (which tended to frown upon the notion of competing for patients).
- 1.7 On the other hand, GPs in Ireland are exposed more directly to competition than their European counterparts. In many European countries, there is universal access to free GP services. Ireland is unusual in a European context in that the majority of our population (66%) pays for GP services. GPs are free to charge private patients whatever they feel the market will bear. Private patients, for their part, are free to “shop around” if they are unhappy with the price charged.
- 1.8 Competition for both public and private patients is curtailed by elements of the General Medical Services (“GMS”) scheme which restrict the number of GP practices in Ireland and protect established GP practices from competition by newly-qualified GPs. The nature of the restrictions imposed by the GMS, the impact they have on patients and the Competition Authority’s proposals for addressing them form the subject of Part III of this Report.

Competition policy and GMS reform

- 1.9 Many concerns regarding the existing GMS system involve general issues of health and social policy which require a wider Government approach, running beyond the scope of competition policy. These issues are being actively debated in a number of different fora.⁸
- 1.10 Competition policy can contribute to this wider debate. A debate about the role of, and scope for, competition in general practice is particularly important in the context of current discussions about the future development of the GMS scheme.
- 1.11 Under the GMS scheme, GP services are provided free-of-charge to 1.6 million public patients throughout the State. The vast majority of GP practices in the country participate in the scheme.
- 1.12 The scheme has far-reaching implications for the development of general practice in Ireland. It affects all of the major commercial decisions for newly-qualified GPs, including where they set up in practice, whether they do so in competition with existing GP practices or choose to join an established practice, and the profitability of their practice.
- 1.13 Competition law has been portrayed as an obstacle to GMS reform - this is not the case. There is nothing in competition law which prevents the Health Service Executive (“HSE”) and GP representative bodies from moving ahead with an agenda for reform. The purpose of this Report is to identify ways in which competition can be used as an instrument for positive change within general practice in Ireland.

⁷ The shortage of GPs is discussed in detail in Part I of this Report.

⁸ See, for example, Second Report of the Joint Oireachtas Committee on Health and Children (February 2010); *Report on Primary Medical Care in the Community*; Layte R. (editor), 2009; *Projecting the impact of demographic change on the demand for and delivery of healthcare in Ireland*, ESRI Research Series Number 13.

Structure of the report

- 1.14 Part I of this Report gives an overview of the General Medical Practitioner (“GP”) profession in Ireland. It brings together research data from a wide range of sources. This provides the context for the detailed analysis and policy recommendations contained in the rest of the Report. It looks first at the key factors governing the demand for, and supply of, GP services in Ireland (Chapter 2). It then describes the regulatory environment within which GPs operate and the professional bodies which represent them (Chapter 3).
- 1.15 From a competition perspective, the issues of greatest interest are laws, regulations or administrative practices which affect the entry of new GPs into the market or undermine competition between doctors providing GP services. Part II of the Report examines two specific issues identified by the Competition Authority as unnecessarily restricting competition in GP services. The two issues are -
- GP Training: The training programme for GPs requires that trainees complete all four years of the programme, regardless of the nature and extent of their prior medical experience. No recognition is given for relevant prior clinical training.
 - Advertising: GPs have traditionally been significantly restricted in their ability to advertise their services or to seek to attract new business.
- 1.16 The final part of our Report (Part III) examines how the GMS system affects competition between GPs and shows the impact this has on both public and private patients.
- In Chapter 6, we describe the GMS system and explain how it operates for patients, GPs and for the State.
 - Chapter 7 identifies a number of concerns about the existing GMS system, from a competition perspective. The issues of greatest concern relate, first, to aspects of the GMS system which protect established GMS practices from competition by newly-qualified GPs and, second, to the role of the Irish Medical Organisation (“IMO”) in the process for determining payments to GPs under the GMS. The impact of these factors on patients, and particularly on private patients, is discussed.
 - In Chapter 8, we put forward proposals for addressing the constraints on competition which have been identified within the GMS system.
 - We conclude, in Chapter 9, with a number of specific recommendations for changes to the GMS system, which would result in better outcomes for patients and the State, and which would enable newly-qualified GPs to compete more effectively with established GP practices.
- 1.17 Parts I and II of this Report were first published in December 2009. Part III of the Report was first published in July 2010. This printed version of the Report, which combines all three parts in a single document, was published in December 2010.

Part I



2. OVERVIEW OF THE GP PROFESSION

- 2.1 This chapter considers key aspects of the demand for, and supply of, General Medical Practitioner (“GP”) services in Ireland. It begins with a brief look at the role and functions of GPs. It then examines the demand for GP services and looks at how the price paid for GP visits affects that demand. The latter part of the chapter examines the supply of GPs, describing the major changes which are taking place in the profession, pointing out the implications of these changes for the future supply of GP services and discussing some of the ways in which Government policies impact on this supply. The chapter highlights concerns that the supply of GP services may struggle to keep pace with the anticipated growth in future demand.

The role and functions of GPs

- 2.2 GPs are the doctors who provide primary medical care to the general public. They constitute the first point of contact between the medical profession and the public and act as “gate-keepers” for the profession, referring patients who need more specialised care to other medical and para-medical practitioners.
- 2.3 GPs provide a wide range of services to the public, including:
- Patient examination/diagnosis;
 - Prescribing of medicines;
 - Ordering of tests;
 - Performance of minor surgeries; and
 - Referral of patients to other healthcare providers.
- 2.4 GPs are also active in preventative medicine, providing health education and services such as family planning, immunisation, well woman screening, travel vaccines, insurance medicals or pre-employment medicals.
- 2.5 There are an estimated 2,800 practising GPs in Ireland, representing about 15% of the total number of registered medical practitioners in the country.⁹ Historically, most GPs have operated as self-employed principals or partners in a practice. While this remains the norm, an increasing number of GPs are engaged as employees, often providing services to GP practices on a part-time or sessional basis, or awaiting a full partnership in a GMS practice.¹⁰

⁹ HSE estimate for 2008.

¹⁰ GPs who are engaged as an “Assistant with a view to partnership in the GMS scheme” are employees of the practice and are contracted by the HSE to provide specified services.

Demand for GP services

- 2.6 The demand for GP services is determined primarily by the number of people in the country who are ill at any given time. This, in turn, is determined by the size of the population, and its basic profile (age structure, health status, income levels, etc.)
- 2.7 For any given population size and profile, there will be an underlying level of demand for GP services. The extent to which this demand translates into actual visits to the GP depends to an extent on the price which individual patients have to pay for such visits.
- 2.8 The price paid for GP services in Ireland varies depending on the eligibility status of the patient (public or private) and the type of medical cover held. Public patients receive GP services free of charge. There is no regulation of the fee which private patients pay for GP visits. It will be shown below that patients who have to bear the full cost of GP fees have a considerably lower number of visits than those for whom GP visits are free or subsidised.

State subsidisation of GP services

- 2.9 Over one-third of the population is entitled to free GP visits, under a range of schemes subsidised by the State.
- 2.10 The main schemes provided by the State are:
- **Medical Card:** This entitles the cardholder and his or her dependants to free GP visits, in addition to a wide range of other benefits.¹¹ Eligibility for a medical card is means tested.¹² In September 2009, there were 1.4 million medical cardholders in the State, equivalent to about 33% of the population.
 - **GP Visit Card:** The GP Visit Card was introduced in October 2005. It entitles the holder and dependents to free doctor visits, but not to the range of additional benefits available to medical cardholders. Any person who has applied for, and been deemed ineligible for, the medical card scheme is entitled to be assessed for a GP Visit Card. As with the medical card, eligibility is means tested or based on “undue hardship”. The income thresholds applied are more generous than in the case of the medical card. In September 2009, 94,000 people held GP Visit Cards, representing just over 2% of the population.
 - **Health Act Card:** The Health (Amendment) Act 1996 introduced a special card to assist people who contracted Hepatitis C through the administration of blood or blood products within Ireland. The card entitles patients to free GP visits, plus a range of additional services.¹³ Approximately 1,700 people are covered under this scheme.
 - **Tax Relief:** People who do not qualify for free GP visits are entitled to claim tax relief on the cost of attending their family doctor. The relief is provided at the standard rate of tax (20%). It covers all expenditure on GP fees which has not already been reimbursed from another source.¹⁴ In 2005, approximately 210,000 people claimed tax relief in respect of doctors’ services, at an estimated cost to the State of €34 million.¹⁵ With effect from the tax year 2007, minimum expenditure thresholds no longer apply to tax relief on medical expenses.

11 In addition to free GP visits, cardholders are entitled to free hospital visits, hospital care, personal and social care services, specific dental services, prescription medicines, maternity cash grants on the birth of each child, plus a number of other benefits.

12 Applicants must be ordinarily resident in the State, be over the age of 16 and satisfy one of the following three criteria: (i) have an income below a specified threshold; (ii) qualify by virtue of an ‘undue hardship’ clause; or (iii) qualify automatically by virtue of having a European Union entitlement or belonging to a Government scheme which allows the recipient to retain the medical card.

13 These include public in-patient and out-patient hospital services, hospital care, specific dental and ophthalmic services, prescription medicines, home help and nursing as well as counselling services.

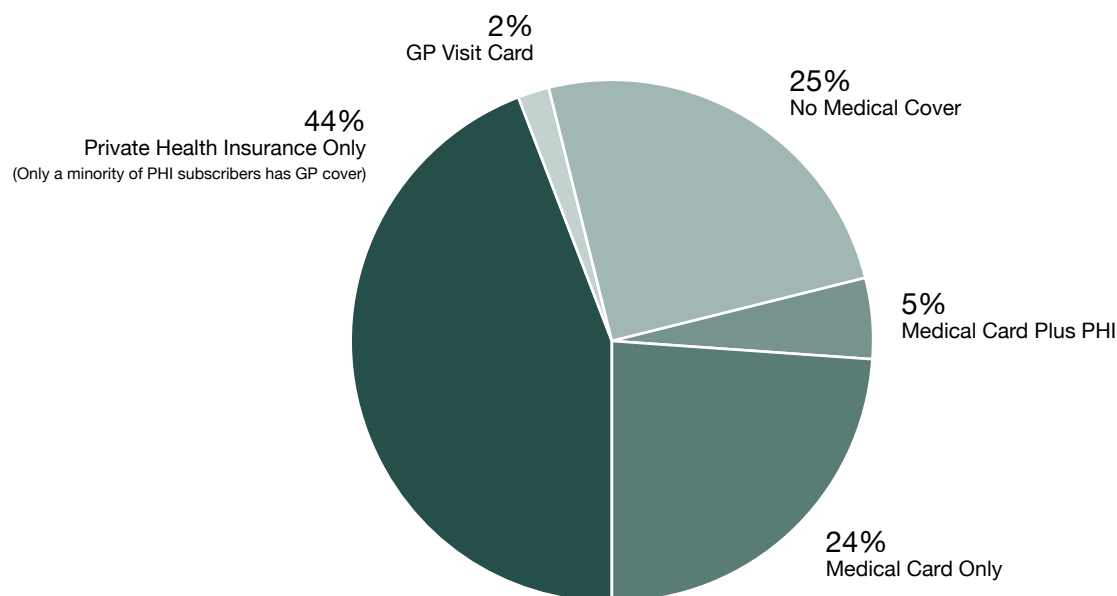
14 Other sources include monies paid out by private health insurers, the HSE or any other reimbursements.

15 Estimates derived from figures supplied by the Revenue Commissioners. The figures relate to all medical practitioners (not just GPs). The total number of applicants for tax relief on medical expenses in 2005 was 260,700. About 80% of these submitted a claim in respect of “Services of a Medical Practitioner”. The cost to the Exchequer of the total tax relief granted in respect of medical expenses in 2005 was €134m, of which about a quarter related to doctors’ fees.

Payments to GPs by private patients

- 2.11 Most people in Ireland do not qualify for free GP visits. Figure 2.1 shows that in 2007 about a third of the population held either a medical card (29%) or a GP visit card (2%). For the vast majority of people who are not covered under these two schemes, GP visits represent a direct out-of-pocket expense (albeit subject to tax relief at the standard rate). (Note that the data in Figure 2.1 relates to 2007. The number of people holding a medical card has risen sharply since 2007 due to the economic downturn. It was noted in paragraph 2.10 above that by September 2009 33% of the population had a medical card and a further 2% of the population had a GP Visit Card).

Figure 2.1: Type of medical cover held, 2007



Source: CSO 2008, Health Status and Health Service Utilisation, Quarterly National Household Survey, Q3 2007

- 2.12 Just less than half the population has private health insurance (49%). Private health insurance (PHI) policies are designed primarily to protect against the cost of secondary care treatments (hospitalisation, major operations, etc.). In recent years, all of the PHI companies have introduced a range of policies which include cover for day-to-day medical expenses, including the cost of GP visits. The level of cover provided varies, depending on the precise plan taken out. In many cases, an excess clause and/or a limit on the number of GP visits per annum applies. For people covered under these schemes, typical cover ranges from €20 to €40 per GP visit.¹⁶ The number of people claiming for GP expenses through their private health insurer is growing. It remains the case, however, that only a minority of PHI policy-holders benefited under these schemes in 2008.
- 2.13 Health Cash Plans provide an alternative source of financial support for primary medical care.¹⁷ Consumers make regular payments to the plan and are able to draw down payments when they incur eligible medical expenses. Cover for routine GP visits varies from €13 - €30, depending on the particular plan.¹⁸ Over 130,000 people in Ireland contribute to such plans.

¹⁶ Figures correct as of October 2008. Based on VHI First Plan, Family Plan and Healthsteps schemes; Quinn Healthcare Family Care, Personal care, Essential and Health Manager Schemes; and Hibernian Health Day-to-Day Plans.

¹⁷ While limited cover is available for hospital stays or day-care surgery, the main focus of health cash plans is on primary care.

¹⁸ Figures based on plans offered by the Hospital Saturday Fund (HSF), 2008.

Price of GP services

- 2.14 In most European countries, there is either universal access to free GP services, or the price of such services is heavily subsidised. In Ireland, the price faced by patients varies depending on the nature of medical cover held: public patients are entitled to free GP visits; most private patients, by contrast, pay the full price of a consultation, although they are eligible to claim tax relief on the costs incurred.
- 2.15 A recent ESRI paper notes that:
- "It is clear that charges (or the absence of them) do influence GP visiting behaviour."*¹⁹
- 2.16 Discussion of the impact of GP fees on patient demand is constrained by the lack of comprehensive price data for the profession. Informal estimates suggest that the cost of GP visits is around €50 - €55 in urban areas, with slightly lower charges in rural areas.²⁰ A range of €45 - €60 in the price charged to private patients is typical.
- 2.17 CSO data provide information on "Doctors' fees", but do not isolate GP fees from those of other medical practitioners. However, since GP fees account for about 70% of overall "Doctors' Fees", price movements in this category should provide a reasonable indication of changes in the level of GP fees. In 2005, expenditure on doctors' fees averaged €193 per household.²¹
- 2.18 Overall, doctors' fees (which include all doctors' fees, in both primary and secondary care) have been rising almost three times as fast as the general level of inflation in the economy. In the period January 2000 - August 2009,²² the Consumer Price Index ("CPI") rose by 30%, while the price index for Doctors' Fees rose by 87% (see Figure 2.2). The divergence in behaviour between doctors' fees and general prices in the economy has become particularly acute in recent months. Figure 2.2 below shows continued growth in doctors' fees during 2009 contrasting with a fall in the CPI over the same period.

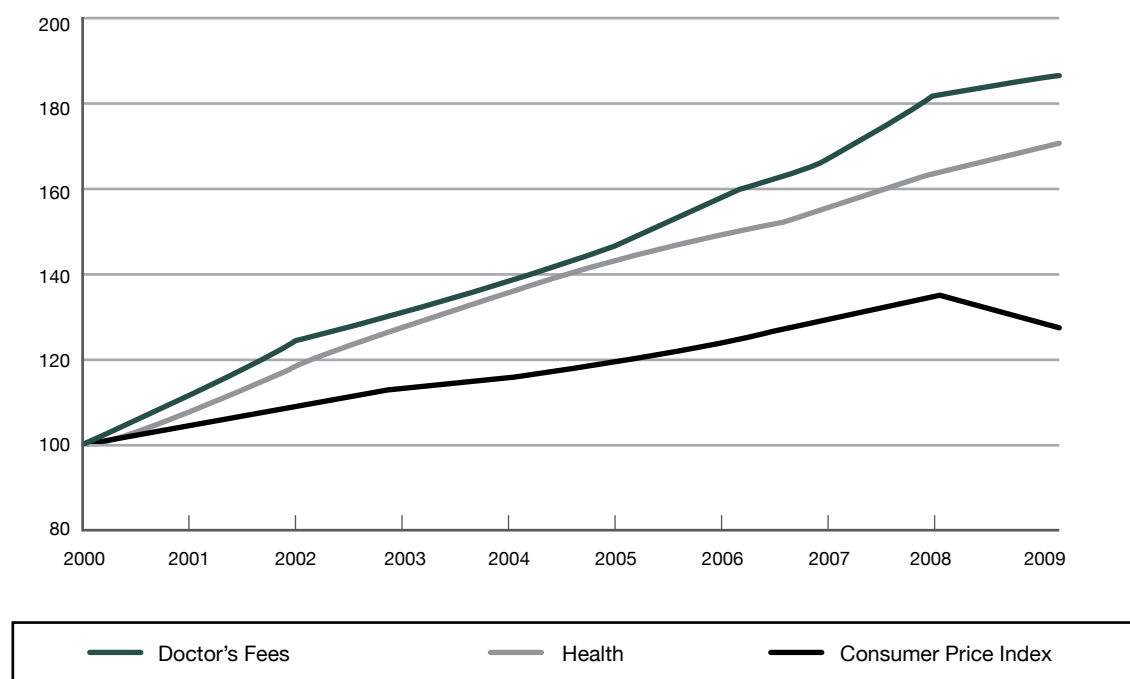
¹⁹ Layte R. and A. Nolan, *Improving access to primary care in Ireland: Do GP charges matter?* ESRI, 2009.

²⁰ Competition Authority informal price check, October 2008. Based on fees charged by 51 GPs in rural and urban locations throughout Ireland.

²¹ Household Budget Survey 2004/2005, CSO.

²² Data for 2009 relate to the period January-August. Source: CSO.

Figure 2.2: Rate of growth in the price of doctors' fees, health inflation and the consumer price index, 2000 – 2009



Source: CSO. Data for 2009 are the average for January-August 2009. All other years are annual averages.

2.19 Until the late 1990s, the cost of a hospital A&E visit in Ireland was substantially less than the cost of a GP visit. Private patients thus had an incentive to go to A&E rather than to their GP. The A&E charge for private patients was increased significantly in 2008 to €100. The *Report of the Special Group on Public Service Numbers and Expenditure Programmes* ("The McCarthy Report") recommended that this charge be increased further to €125.²³ Research carried out in 2004 (prior to the increase in A&E charges) found that, compared to other entitlement groups, people with no medical cover had relatively high rates of utilisation of A&E services.²⁴ This group of patients (who have neither private health insurance nor a medical card) are likely to be particularly cost-sensitive. The substantial increase in A&E charges since 2008 may have resulted in some non-urgent cases being re-directed back towards GP practices.

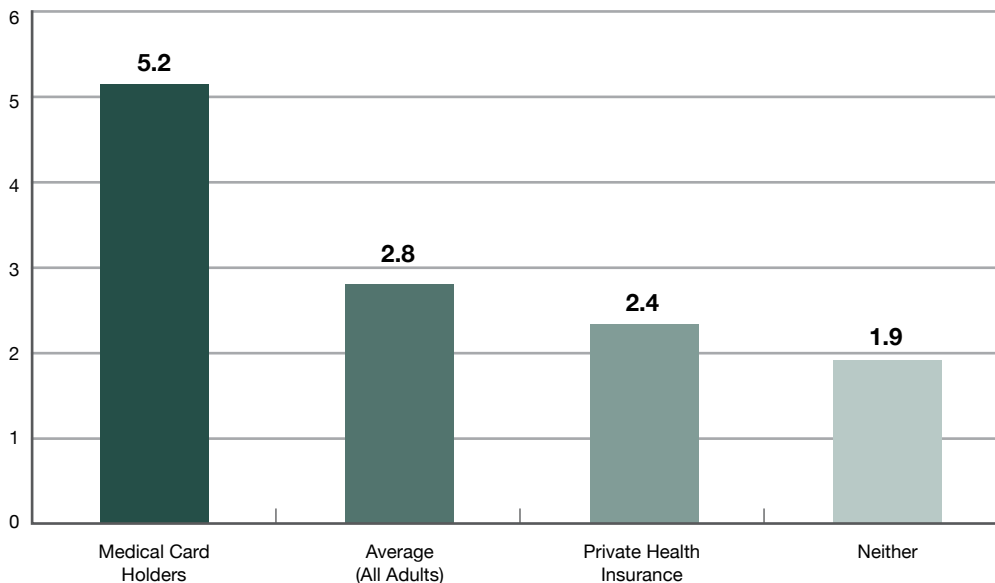
²³ *Report of the Special Group on Public Service Numbers and Expenditure Programmes*, Government Publications, PRN A9/0988, July 2009.

²⁴ Smith S., *Patterns of Emergency Department Utilisation in Ireland: Findings from four large teaching hospitals in Dublin*, in Nolan B. *op cit.* 2008.

Impact of GP charges on frequency of visits

- 2.20 Two out of every three adults in the State consult their GP at least once a year. The average number of consultations by adults is 2.8 visits per annum.²⁵
- 2.21 Individuals who receive GP services free-of-charge have significantly higher visitation rates than those who pay for their GP visits. In 2007, persons with a medical card visited their GP an average of 5.2 times (Figure 2.3). This compares with an average of 2.4 visits among those with private health insurance and only 1.9 visits for those with no medical cover.²⁶ Thus, while medical card holders make up about one-third of the population, they account for over 50% of all GP visits.

Figure 2.3: Average number of GP visits per annum by type of medical cover, 2007



Source: CSO, 2008, Health Status and Health Service Utilisation, Quarterly National Household Survey, Q3 2007.

- 2.22 Extensive research has been carried out in an attempt to explain why the rate of GP visitation in Ireland differs so markedly between public and private patients. Nolan and Nolan (2007) note that –

*“The difference in relative prices faced by medical card and private patients obviously impacts on patient behaviour”.*²⁷

They suggest that –

*“The size of the gap between medical card holders and private patients suggests that neither level of visiting is optimal, i.e., that medical card patients are to some extent ‘over-consuming’ GP services, and private patients ‘under-consuming’ services’.*²⁸

²⁵ CSO, 2008, *Health Status and Health Service Utilisation, Quarterly National Household Survey, Q3 2007*.

²⁶ The figures given here are ‘age-standardised’ results. They have been adjusted to take account of differences in the age profile of the different categories of patient (notably the higher average age of medical card holders). The raw (non-standardised) data show an even larger gap between the average number of visits by medical card holders and other categories of patient.

²⁷ Nolan A. and B. Nolan, *Income, Medical Card Eligibility and Access to GP Services in Ireland*, in B. Nolan (ed.), *The Provision and Use of Health Services, Health Inequalities and Health and Social Gain*, ESRI, 2007.

²⁸ Nolan and Nolan, *op. cit.*, page 77.

- 2.23 A key concern of the research has been to try to isolate the impact of medical card ownership from other factors which impact on GP utilisation, such as differences in the underlying health status, age profile or socio-economic profile of public and private patients. A number of recent studies confirm that, even after controlling for these factors, medical card holders are significantly more likely to visit their GP and visit more often on average than non-medical card holders:
- Nolan and Nolan found that medical card patients have an average of between 1.1 and 1.2 more GP visits per annum than non-medical card holders, even after controlling for other identifiable influences on visiting.²⁹
 - Analysis carried out by the CSO suggests that, all other things being equal, a person with a medical card will be two and a half times more likely to have a high number of GP visits (more than five visits per annum) than a non-medical card holder.³⁰
- 2.24 The McCarthy Report noted the pressures on the public finances resulting from the “demand-led” medical card scheme. It recommended that the eligibility criteria for the medical card be tightened and focused on medical need.
- 2.25 The impact of GP charges on private patients is the subject of some debate. A number of recent studies suggest that private patients in Ireland may be “under-utilising” GP services due to cost factors. O’Reilly *et al.*, in a survey of GP patients in Ireland undertaken in 2003, found that 18.9% of patients had a medical problem during the year but did not consult their GP due to cost.³¹ Nolan and Nolan (2007) found that the major difference in GP visiting in the Republic is between medical card and private patients, rather than between private patients on differing incomes.³² These findings are supported by a number of recent reports which suggest that a significant number of private patients are delaying GP visits due to cost factors or are “shopping around” for cheaper consultation fees.³³

Supply of GP services

- 2.26 The path to becoming a GP in Ireland has changed significantly since the mid-1990s. In the past, it was not unusual for doctors to set up as GPs once they had completed their basic training and qualified as a Medical Practitioner. There was no requirement for specific vocational training in General Practice. In recent years, the route to becoming a GP has become highly structured, with a lengthy period of vocational training before doctors qualify as GPs. Figure 2.4 shows the path which must now be followed by doctors who wish to be recognised as Specialist GPs in Ireland.

²⁹ Nolan and Nolan, *op. cit.*

³⁰ A high number of GP visits is defined as more than 5 visits in the previous twelve months. CSO, 2008, *op. cit.* pages 19-20.

³¹ O’Reilly, D., T. O’Dowd, K. Thompson, A. Murphy, C. O’Neill, E. Shryane, K. Steele, G. Bury, A. Gilliland and A. Kelly (2006), *Consultation Charges in Ireland Deter a Large Proportion of Patients from seeing the GP: Results of a Cross-Sectional Survey*, mimeo, Belfast: Department of Epidemiology and Public Health, Queen’s University.

³² Nolan and Nolan, (2007) *op. cit.*

³³ A national survey of 100 GPs, carried out by the *Irish Medical Times*, reported that 63% of respondents believe that patients are delaying visits to their GP due to financial constraints. *The Irish Examiner*, 2 March 2009. A similar pattern was reported in a survey carried out by www.rollercoaster.ie in August 2008 on behalf of the HSF Health Plan. The *Irish Times* has reported that a number of patients in border counties are visiting GPs in Northern Ireland, where average prices are less than €35 and can be as low as €25. (*Irish Times*, 23/3/09, p6)

Figure 2.4: Education and training required to practise as a GP in Ireland



2.27 There are a number of critical steps for those who want to train and subsequently practise as a GP in Ireland. Aspiring GPs must first secure a place in university to train as a Medical Practitioner. Once they have qualified as a doctor, they must then gain admission to a GP training programme. Finally, qualified GPs who wish to treat public patients within their own GP practice must secure a GMS contract from the HSE. These three steps are discussed below.

- 2.28 **Access to medical college:** A major reform of medical education and training in Ireland was announced in 2007, following the publication of the Buttimer and Fottrell Reports.³⁴ Prior to 2006, the number of Irish/EU students entering medical school was “capped” at 305 per annum. The reforms envisage a significant increase in the total number of doctors graduating from Irish medical schools, with a growing proportion of these places being made available for Irish and EU students.³⁵ The ESRI estimates that the number of Irish/EU students graduating from medical school in Ireland will rise to about 456 per annum over the next few years.³⁶ Additional capacity has been provided by increasing the number of places available at undergraduate level and by introducing a new graduate-entry programme. Undergraduate courses in medicine are provided in five third level colleges in Ireland: University College Dublin (“UCD”), Trinity College Dublin (“TCD”), University College Cork (“UCC”), National University of Ireland Galway (“NUIG”), and the Royal College of Surgeons in Ireland (“RCSI”). Graduate Entry Programmes are currently available in four third-level colleges: UCD, UCC, University of Limerick (“UL”) and RCSI. The first cohort of students to enter these graduate programmes will qualify in 2011. Despite the increase in the number of places available in medical schools since 2007, courses remain heavily oversubscribed and competition among Irish and EU students to secure a place remains intense.
- 2.29 **Access to GP training posts:** The number of new GPs qualifying in Ireland each year is determined effectively by the number of training posts available on training courses approved by the Irish College of General Practitioners (“ICGP”). In 2009, there were 120 approved GP training posts available on thirteen GP training programmes throughout the State.³⁷ There are usually at least three applicants for every post on offer. The number of applicants for GP training posts is likely to rise after 2012, as the first doctors qualifying from the new Graduate Entry Programmes come on stream and the impact of the increased numbers entering medical college at undergraduate level makes itself felt.
- 2.30 **Access to GMS contracts:** The number of GMS contracts determines how many GPs in Ireland are allowed to treat public patients within their own practice.³⁸ Since public patients account for over 50% of all GP visits in the State, the ability to treat such patients is critical for GPs who want to practise on their own account. In 2008, one out of every four GPs (approximately 700 GPs) did not have a GMS contract. Most of these GPs work within the practice of another GMS-contracted GP, where they are entitled to treat public patients. A small minority of GPs without a GMS contract run their own practices, focusing exclusively on private patients.
- 2.31 The remainder of this chapter examines a number of issues relating to the supply of GP services in Ireland, under the following headings:
- Existing supply of GP services;
 - Changes in the nature of GP practices;
 - Adequacy of future supply;
 - GMS contracts for GPs; and
 - GP incomes.

34 *Medical Education in Ireland: A New Direction*, Report of the Working Group on Undergraduate Medical Education and Training (the “Fottrell Report”), Department of Health and Children (2006); *Preparing Ireland’s Doctors to meet the Health Needs of the 21st Century*, Report of the Postgraduate Medical Education and Training Group (the “Buttimer Report”), Department of Health and Children, (2006).

35 The reforms announced by the Department of Education and Science in 2007 envisaged the number of places available for Irish/EU students rising from 305 *per annum* in 2006 to 725 *per annum* by 2010/2011. See press release dated 16 December 2007 www.education.ie. In 2009, approximately 400 places were available on undergraduate medical courses in Ireland. In addition, approximately 200 places were available in 2009 to graduates entering the new graduate-entry medical programmes. This equates to a total of about 600 places on medical courses in 2009. A significant proportion of the total places available in Irish medical schools are taken up by non-EU students, who provide an important source of funding for the universities. It would appear from these figures that the number of places available for Irish/EU students remains well below the targeted level of 725 *per annum*.

36 Thomas S. and R. Layte (2009), *op.cit.*

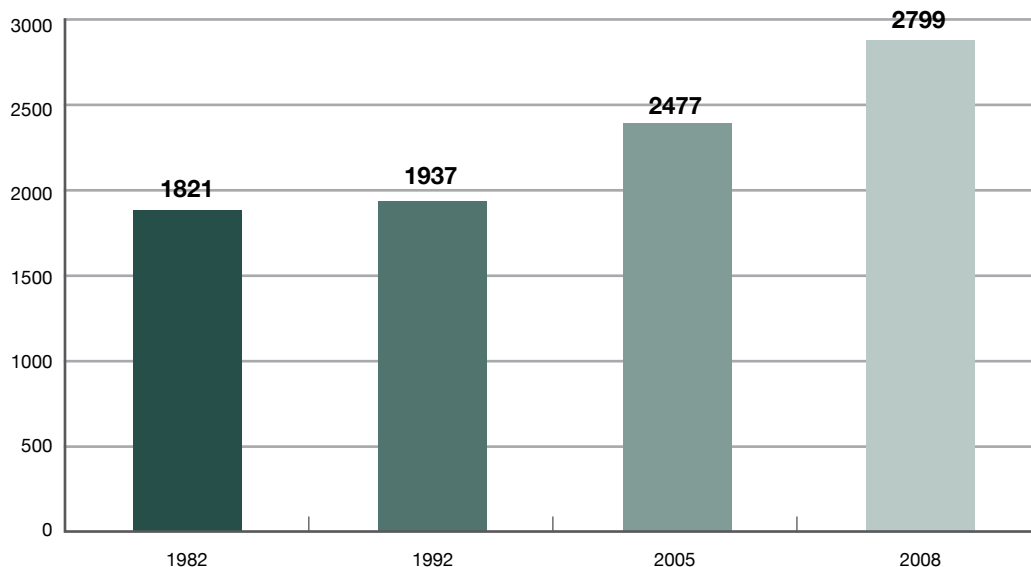
37 See www.icgp.ie for details.

38 GPs that do not have a GMS contract are entitled to treat public patients within the practice of a GMS-contracted GP.

Existing supply of GP services³⁹

- 2.32 Information on the number of practising GPs in Ireland has, up to now, been very difficult to compile. Under the old (1978) Medical Practitioners Act, it was not possible to distinguish GPs from other types of Medical Practitioner on the General Register. Under the new (2007) Medical Practitioners Act, GPs are, for the first time, required to register as a GP specialist. The new rules on registration came into effect in March 2009 and should allow comprehensive data on the profession to be collated in future years.
- 2.33 Estimates of the number of practising GPs in Ireland have been prepared for the years 1982, 1992 and 2005.⁴⁰ These suggest that the total number of GPs in Ireland rose from 1,821 in 1982 to 2,477 in 2005. Separate estimates from the HSE put the number of practising GPs at 2,799 in 2008. The HSE estimate is not directly comparable with the figures for the earlier years. It does, however, provide the best available indication of the trend in numbers since 2005 (see Figure 2.5).

Figure 2.5: Number of GPs in Ireland, 1982 – 2008



Sources: Estimates for 1982, 1992 and 2005 from O'Dowd *et al.* (2008). Estimate for 2008 is from the HSE. The figure for 2008 is not directly comparable with the estimates for previous years.

- 2.34 Table 2.1 shows that the growth in the number of GPs over the period 1982–2008 outpaced the growth in Ireland's population. The number of GPs per thousand population grew from 0.52 in 1982 to 0.63 in 2008. Another way of looking at this is to note that in 1982, there were 1,911 people for every GP in the country. By 2008, the number of people per GP had fallen to 1,580, a drop of 27%.

³⁹ This section draws heavily on the following two reports: O'Dowd, T. M. O'Kelly and F. O'Kelly (2008), *Structure of General Practice in Ireland 1982-2005*; O'Kelly F., M. O'Kelly, A. Ni Shuilleabhain and T. O'Dowd (2008, draft), *A National Census of Irish General Practice Training Programme Graduates 1997-2003*.

⁴⁰ O'Dowd *et al.* (2008).

Table 2.1: Number of GPs (per thousand of population), Ireland, 1982, 1992, 2005 and 2008

	1982	1992	2005	2008
Number of GPs	1,821	1,937	2,477	2,799
Total Population ('000s)	3,480	3,554	4,133	4,422(e)
Number of GPs per thousand population	0.52	0.55	0.60	0.63

Source: GP data as per Figure 2.5; population data from CSO.

2.35 Despite the rise in the number of GPs in Ireland since 1982, international data suggest that the supply of GPs in Ireland remains low relative to most other OECD countries. Table 2.2 shows that Ireland has only 60% of the number of GPs per 1,000 population compared to Germany or the US and only about two-thirds the number of most continental European countries. Like Ireland, other countries have witnessed a slow but steady rise in the number of GPs per head of population over the past decade. This means that the gap between Ireland and other countries in terms of the supply of GPs has failed to diminish over time.

Table 2.2: Number of GPs (per thousand of population), international comparisons, 2005

Country	Number of GPs (per thousand of pop)
Germany	1.0
US	1.0
Italy	0.9
Spain	0.9
UK	0.7
New Zealand	0.7
Ireland	0.6

Source: OECD Health Data 2007. Data for Ireland from O'Dowd et al (2008). The O'Dowd figures are used for Ireland since they provide the best available estimate of the number of practising GPs in the country in that year. Note that if the data for Ireland had been taken directly from the OECD Health Data report, it would show a lower figure of 0.5 GPs per thousand population, pointing to an even wider gap between Ireland and other countries than the above table suggests.

- 2.36 Recent work by the ESRI provides important insights into the regional distribution of GPs in Ireland.⁴¹ It suggests that in 2008 Cork, Galway and Waterford were best supplied in terms of GPs, while Clare, Offaly, Monaghan and the east coast commuter counties of Laois, Meath and Kildare had the poorest supply relative to population. The report concludes that, without intervention, there is likely to be “*a profound and worsening problem of distribution of GPs across the country*”. Inland commuter counties in Leinster are deemed most likely to suffer in terms of an under-supply of GPs in the future, if the number of GPs in these areas fails to keep pace with the predicted growth in population.

Changing nature of GP practices

- 2.37 The GP profession has undergone significant change in the past two decades. Key changes include:
- The “feminisation” of the profession, with female GPs accounting for a rapidly increasing proportion of total GPs;
 - A movement away from sole practitioners towards multi-partner practices;
 - An increase in the level of specialist vocational training by GPs; and
 - An increase in the proportion of GPs working part-time.
- 2.38 Changes in the structure and organisation of the GP profession mean that a significant increase in the number of GPs will be required in the future, simply to deliver the current level of GP services. Studies of recent GP graduates point to dramatic differences in their gender distribution and work patterns, compared to the stock of existing GPs.⁴² These studies suggest that recently qualified GPs will, on average, have a shorter working life than their predecessors and will spend fewer hours per week engaged in face-to-face patient consultation. They are more likely to be female, more likely to be engaged in part-time practice and hope to retire at an earlier age than their predecessors.
- 2.39 There has been a rapid increase in the number of female GPs over the past 25 years, reflecting the significant growth in the number of women entering medical schools. In 2005, 30% of all GPs in Ireland were female, up from just 12% in 1982. The change is even more apparent when we consider those graduating from GP training programmes: 70% of those who graduated between 1997 -2003 were female, compared with just 6% in 1975 -1979. Given the higher propensity of recently-qualified female GPs to engage in part-time practice, this trend has major implications for the future supply of GP services.⁴³
- 2.40 Recent changes in the entry requirements for undergraduate entry to medical school⁴⁴ have resulted in a significant shift in the gender balance of new entrants, with the proportion of male entrants rising from 40% in 2008 to 48% in 2009. It is too early to say whether this represents a break in trend. If the pattern of undergraduate admissions in 2009 were to continue in the years ahead, we could expect the gender balance of the profession to gradually become more equal.
- 2.41 Of those who graduated from GP training programmes between 1997 and 2003, only 43% are currently involved in full-time clinical general practice.⁴⁶ Among the recent graduates surveyed, less than three out of every five male GPs and only one-third of female GPs were engaged in full-time practice.⁴⁷

41 Layte R. (editor), “*Projecting the Impact of Demographic Change on the Demand for and Delivery of Healthcare in Ireland*”, ESRI Research Series Number 13, (October 2009).

42 O’ Kelly *et al.* (2008).

43 O’ Kelly *et al.* (2008).

44 In 2009 a new system was introduced for school-leavers applying for medical college in Ireland. The system combines the results of the Leaving Certificate examination with those of an aptitude test (the HPAT), which is designed to assess candidates’ abilities in the area of logical reasoning, problem-solving and non-verbal reasoning.

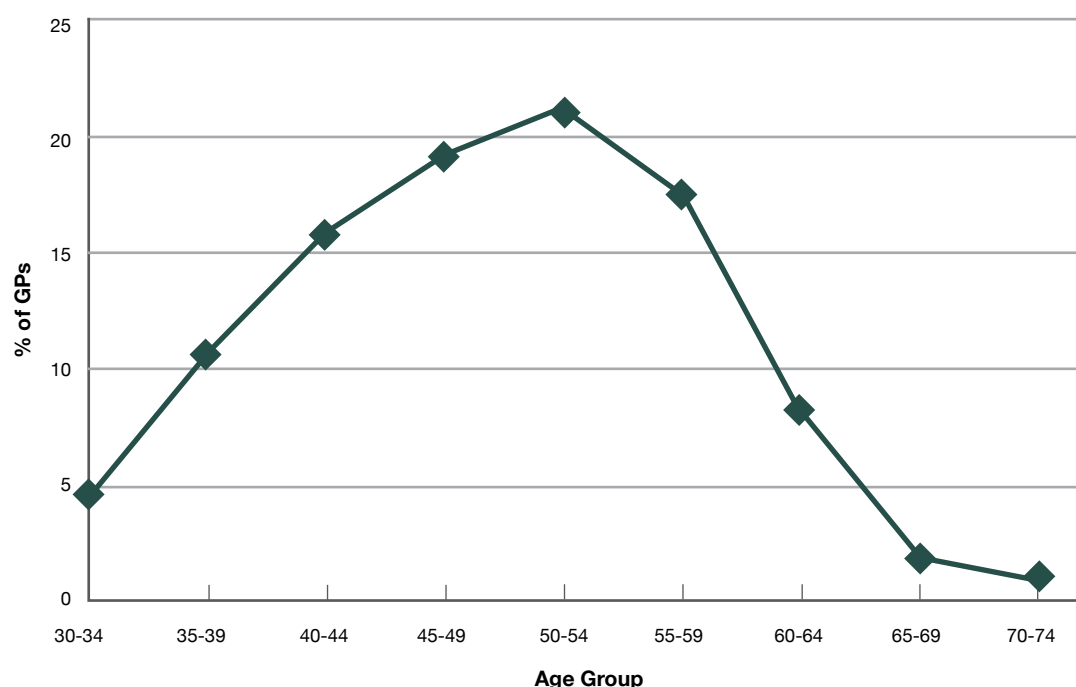
45 There have been suggestions that the changes in the entry requirements for undergraduate medicine were motivated, in part, by a desire to improve the gender balance in the profession. This suggestion has been rejected by the heads of all the medical schools in Ireland (*The Irish Times, Letters to the Editor*, 28 August 2009).

46 Full-time clinical general practice is defined as nine or more clinical sessions per week. O Kelly F., *et al* (2008).

47 Of those who graduated from GP training programmes in 1997 – 2003, 57% of males and 32% of females were engaged in full-time practice at the time of the survey in 2007. O’Kelly *et al* (2008)

- 2.42 Figure 2.6 shows the age distribution of GPs in 2005. Most GPs are aged between 35 and 60 years. The age profile of GPs has become more concentrated over time, with fewer GPs falling into both the younger (under 30) and older (over 65) age groups. This reflects, first, increased participation in GP training schemes and an increase in the duration of such schemes, both of which have curtailed the growth in the number of GPs at the younger end of the age spectrum. Second, there has been a significant decline in the percentage of GPs continuing in practice after the age of 64. The proportion of GPs still in practice after the age of 64 fell from 8% in 1992 to just 3% by 2005. Among younger GPs generally,⁴⁸ and among young female GPs in particular,⁴⁹ there is a strong preference for early retirement. This suggests that losses due to retirement are likely to become increasingly significant in the years ahead.

Figure 2.6: Age distribution of GPs, 2005



Source: O'Dowd et al (2008).

- 2.43 Changes in the structure of GP training, and the formalisation of general practice as a distinct specialty within the wider medical profession, mean that younger GPs have much higher levels of practical training than their older counterparts. Overall, 36% of GPs in 2005 had completed a formal three-year training programme, up from 28% in 1992 and just 9% in 1982. As would be expected, the overall figures mask stark differences across the various age categories. In the youngest age group (30-34 years), only 5% of GPs received no vocational training, whereas among GPs aged 55+, the vast majority received no vocational training.⁵⁰
- 2.44 GPs increasingly combine their traditional work of patient consultations with other non-clinical work. Of those who graduated from GP training programmes in 1997-2003, 44% work at least one non-clinical session each week, undertaking teaching, research and continuing education. Almost a quarter (24%) of these recent graduates combines general practice with another area of medicine, typically in the area of academic activity.⁵¹

48 Among GPs aged 30 – 39 in 2005, 68% planned to retire before the age of 65. This compares with 52% of those aged 40 – 49 and 32% of those aged 50 – 59. O'Dowd et al (2008).

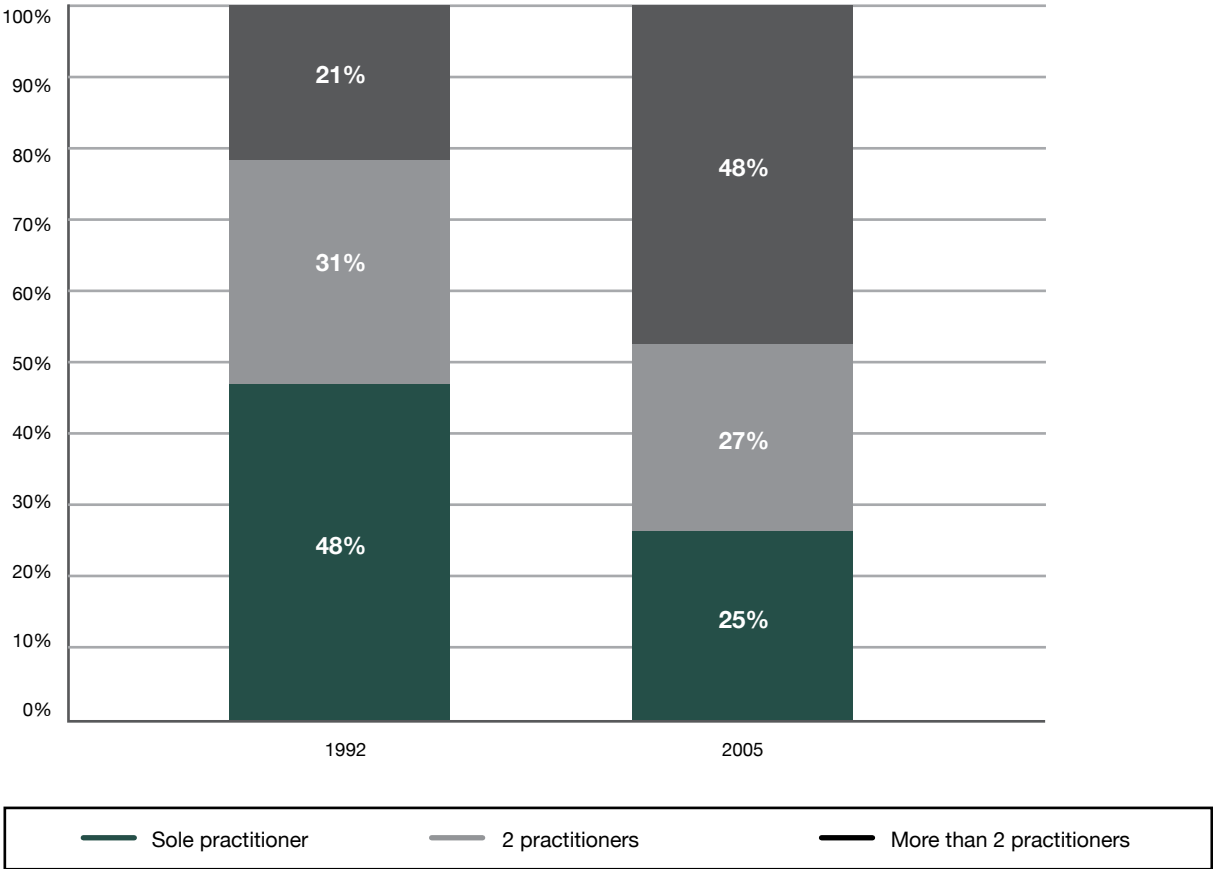
49 In 2005, 28% of female GPs reported that they would prefer to retire before the age of 60. This compares with only 6% of male GPs.

50 In 2005, 79% of GPs aged 55-59 and 71% of GPs aged 60-64 had received no vocational training. O'Dowd et al (2008:19).

51 O'Kelly et al (2008).

2.45 The structure of GP practices has changed dramatically in recent years. The traditional pattern of GPs operating as sole practitioners has given way to a system where multiple-partner practices and co-ops have become the norm. Figure 2.7.1 shows that, between 1992 and 2005, the number of single-partner practices fell by almost half in urban areas (from 48% to 25%). By 2005, almost half (48%) of all GP practices in urban areas had more than two partners.

Figure 2.7.1: Number of partners in GP practices (urban areas), 1992 and 2005

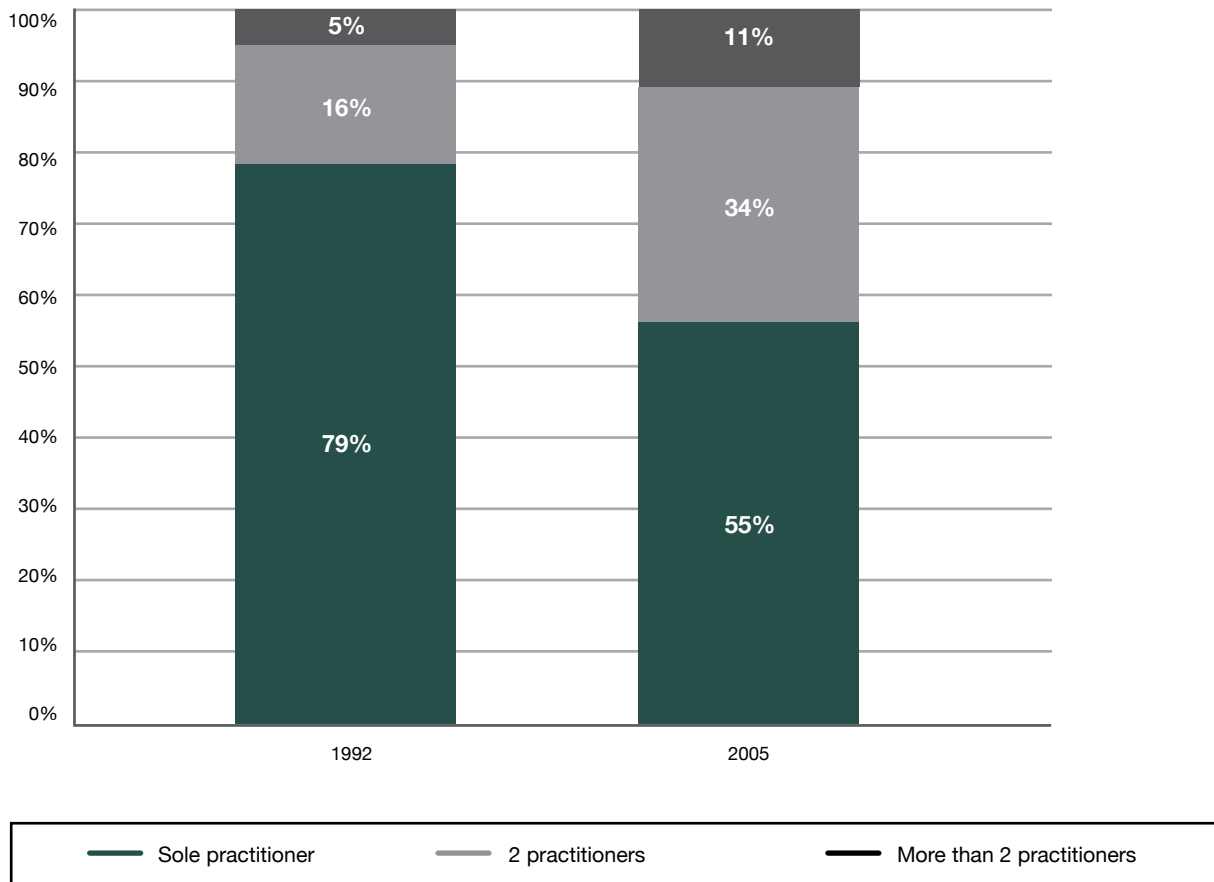


Source: O'Dowd *et al* (2008)

2.46 Figure 2.7.2 shows that the number of single-partner practices fell from 79% to 55% in rural areas over the same period. The proportion of multi-partner practices in rural areas, while still lower than in urban areas (11% in 2005), is rising rapidly from a low starting base. This trend is seen as a positive development by both medical practitioners and professional bodies, contributing to the better delivery of GP services and to a better working environment for GPs.⁵²

52 Medical Council and Irish College of General Practitioners.

Figure 2.7.2 Number of partners in GP practices (rural areas), 1992 and 2005



Source: O'Dowd *et al* (2008)

- 2.47 The changing structure of GP practices has facilitated significant changes in the provision of out-of-hours services by GPs. Co-Ops have been set up by groups of doctors from different practices to provide these services. In 2005, 42% of all GPs were involved in Co-Ops, and Co-Ops had replaced internal and other practice rotas as the most widely used method of providing out-of-hours services.
- 2.48 The move towards larger, multi-partner GP practices increases the viability of engaging practice nurses, who may be able to undertake some of the tasks which GPs in smaller practices have to perform themselves. Practice nurses may, for example, take blood pressure readings, arrange blood tests, monitor patients' weight, etc. In a busy surgery, this can free up the GP, enabling him/her to see more patients.

Adequacy of future supply

- 2.49 A number of recent reports have expressed serious concern about the adequacy of the supply of GPs in Ireland in the years ahead. A report by FÁS suggests that, if the population continues to grow at a steady rate of 0.7% per annum and if current trends in terms of the feminisation of the GP profession and the increased propensity for part-time work among both male and female GPs continue, there will be a significant and growing shortfall of GPs in Ireland over the next decade.⁵³
- 2.50 The FÁS Report attempts to quantify the gap in GP services which might result from the feminisation of the GP workforce and the general increase in part-time work.⁵⁴ It suggests that, by the year 2020, an additional 175 GPs will be required simply to ensure a continuation of existing levels of service delivery.
- 2.51 A recent report by the ESRI paints a similar picture.⁵⁵ It indicates that, by the period 2016-2021, 126 additional GPs will be required each year, simply to keep pace with the demand resulting from population growth and retirements. If the supply of GPs per head of population is to be brought into line with the EU average, the number of additional GPs required each year will increase still further, to 201.
- 2.52 Historically, a significant proportion of newly-qualified doctors have sought to train as GP specialists, with only about 25% of applicants proving successful in securing a place on an ICGP training programme. The number of Irish and EU students qualifying from Irish medical schools is increasing, due to the increased number of college places on offer (see paragraph 2.28 above). Past trends suggest that many of these doctors will want to train as GP specialists. A key constraint on the future supply of GPs therefore will be the availability of an adequate number of GP training posts.
- 2.53 The FÁS Report referred to in paragraph 2.49 above provides an indication of the shortfall in supply which might emerge if the intake to GP training posts were to remain at the existing level of 120 places *per annum*. The ESRI shows that, even if the number of GP training posts were increased to 150 *per annum*, Ireland would fail to maintain (much less increase) the current GP-to-population ratio. It suggests that the number of GP training posts would need to rise to 250 in order to compensate for population growth and retirements, and begin to make some progress in improving the supply of GPs to bring it into line with the EU average. The issue of GP training and access to existing training programmes is discussed in detail in Part II of this Report.

State contracts for GPs

- 2.54 Three out of every four GPs in Ireland are contracted by the State to provide services to public patients under the GMS scheme. This contract is signed with the HSE which reimburses doctors for the care they provide, through the Primary Care Reimbursement Service (PCRS). GPs who do not obtain a GMS contract (approximately 700 GPs in 2008) are only entitled to treat public patients within the practice of a GMS-contracted GP. If they wish to set up in practice on their own, they are restricted to treating private patients only.
- 2.55 GPs who hold a GMS contract are reimbursed by the State under a “capitation” system.⁵⁶ They receive a payment based on the number of public patients on their list and the “profile” of these patients. Payments are weighted to take account of each patient’s age, sex and the distance from their residence to the GP’s surgery. In 2008, total payments to GPs under the GMS scheme amounted to €460 million. This equates to an average payment of around €65 for every visit made by a public patient.

⁵³ FÁS/Expert Group on Future Skill Needs (2009), *A Quantitative Tool for Workforce Planning in Healthcare: Example Simulations*, June.

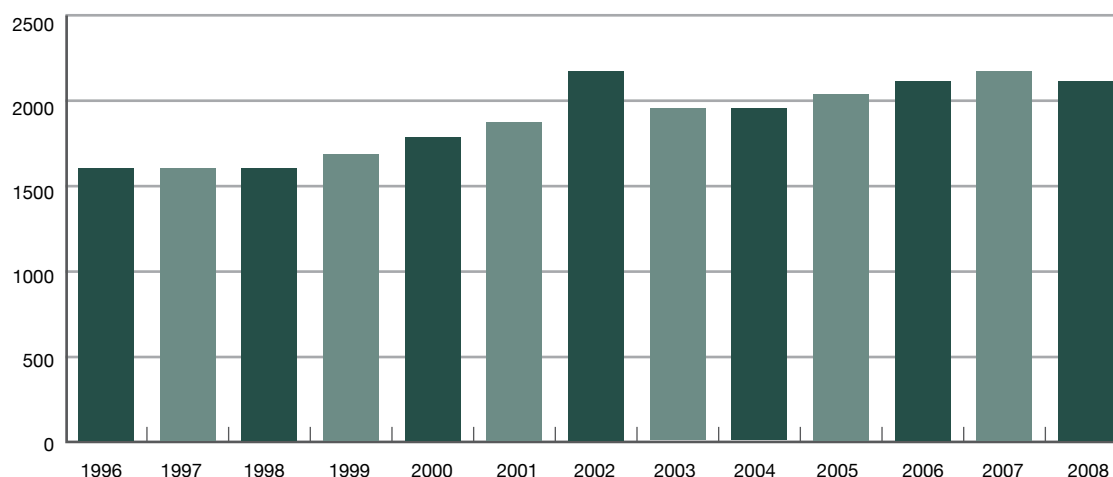
⁵⁴ FÁS/ESGFSN Report, 2009, *op. cit.*

⁵⁵ ESRI Research Series Number 13, (October 2009), *Projecting the Impact of Demographic Change on the Demand for and Delivery of Healthcare in Ireland*.

⁵⁶ Under the GMS contract, GPs also receive fee-per-item payments for the delivery of certain services. In 2007, total payments to GPs under the “Item of Service” contract and “Special Claims/Services” amounted to €36.4m, equivalent to 0.8% of payments to doctors under the GMS scheme. Source: HSE PCRS *Statistical Analysis of Claims and Payments 2007*, Table 3, page 37.

- 2.56 Capitation payments provide GPs with an incentive to attract and compete for patients. GP remuneration is based on the size and composition of their list, rather than on the number and length of patient consultations. The typical GP with a GMS contract has between 500 and 1,000 public patients on their list. In 2007, 43% of all GPs with a GMS contract fell into this size category. The maximum list size for public patients is 2,000.⁵⁷
- 2.57 Obtaining a State contract is of fundamental importance to most GPs. First, without a GMS contract, a new GP practice cannot access a group of patients who account for over 50% of all GP consultations in the State. Second, the contract provides GPs with a regular income based on capitation payments for every public patient on their list. Importantly, it also entitles them to superannuation benefits and a range of significant ancillary benefits.⁵⁸ These ancillary benefits include contributions towards the cost of hiring a *locum* to cover holidays or sick leave, together with payments towards practice services, such as the provision of secretarial and nursing support.
- 2.58 The importance of a GMS contract to the operation of a GP practice is reflected in the very small number of GPs who provide services solely to private patients. The percentage of GPs in private practice alone fell from 11% in 1982 to just 4% in 2005, with most of the fall occurring in the period after 1992.⁵⁹ Of those GPs who are engaged in private practice alone, virtually all have been in practice for less than ten years.
- 2.59 The number of State contracts available and subsequently awarded to GPs is determined by the HSE, in consultation with the Irish Medical Organisation (“IMO”).⁶⁰ In 2008, 2,098 GPs held a GMS contract. This represents 75% of the estimated total of 2,800 practising GPs in Ireland.
- 2.60 The number of GP contracts under the GMS scheme increased by 27% in the period 1996-2008, from 1,647 to 2,098 (see Figure 2.8 below). The number of contracts rose steadily between 1998 and 2001, with a noticeable spike in 2002 coinciding with the introduction of automatic entitlement to medical cards for all people over the age of 70. Since 2002, the number of GMS contracts has remained fairly steady, within the range 2,000-2,100.

Figure 2.8: Number of GP contracts under the GMS scheme, 1996-2008



Source: HSE

⁵⁷ In 2007, 7 GPs (0.3%) had list sizes in excess of 2,000. Source: HSE, *PCRS Statistical Analysis 2007*, page 50.

⁵⁸ Under the GMS contract, the HSE contributes a sum equivalent to 10% of a GPs capitation payments into a superannuation fund. The GPs themselves contribute a sum equivalent to 5% of their capitation fees into the same fund.

⁵⁹ O'Dowd *et al* (2008).

⁶⁰ The Irish Medical Organisation is a representative body for medical practitioners.

- 2.61 Efforts to contrast the growth in the number of GMS contracts with the growth in the overall number of GPs, to see how the gap between them has changed over time, are hindered by two things: First, estimates of the number of GPs are only available for the years 1982, 1992, 2005 and 2008. Any discussion is limited, therefore, to these four specific points in time. Second, HSE data for the years prior to 1996 include information on GPs who do not hold GMS contracts, but who are registered to provide services under a range of other schemes, such as the Primary Childhood Immunisation Scheme and the Methadone Treatment Scheme. It is only since 1996 that it is possible to separate out GMS-contracted GPs from those who hold other forms of contract with the HSE.
- 2.62 Despite the limitations of the data, the evidence suggests that the availability of GMS contracts has improved since the 1980s. The proportion of GPs holding a GMS contract rose from an estimated 70% in 1982 to 81% in 2005 (Table 2.3).⁶¹ The figures indicate some fall-back since 2005, to 75% in 2008. A significant feature in the figures for 2008 is that, while the number of GMS contracts fell back slightly that year (from 2,129 in 2007 to 2,098 in 2008), there was a dramatic rise in the number of GPs holding more limited contracts (“non-GMS contracts”) for the provision of services under the individual schemes described in paragraph 2.60 above. In 2008, 501 GPs held a “non-GMS” contract, compared with only 218 the previous year. This number is more than twice the norm for non-GMS agreements and marks a sharp departure from previous experience.

Table 2.3: Estimated percentage of GPs holding a GMS contract, 1982-2008

	1982	1992	2005	2008
Number of GPs	1,821	1,937	2,477	2,799
Number of GMS Contracts	1,276(e)	1,472(e)	2,018	2,098
Estimated percentage of GPs holding a GMS Contract	70%(e)	76%(e)	81%	85%

Source: GP estimates from Figure 3.5. Data on GMS contracts from HSE.

Note: Estimates of the number of GMS contracts in 1982 and 1992 are based on an assumption that GMS agreements accounted for 90% of total agreements with GPs in these years. This would be broadly in line with the trend since 1996. The estimates for these years should be regarded as purely indicative in nature.

- 2.63 The increased availability of GMS contracts for GPs is reflected in a drop in the average number of applicants per contract. In the 1980s, GMS contracts would typically attract around 20 applicants. It is now not unusual to have a single (or even no) applicant for posts in certain areas. An exception to this trend is in large urban areas, where there is still a strong demand from GPs in private-only practice to expand into public practice.
- 2.64 The number of applicants for GMS contracts varies from region to region. In 2008, the highest number of applicants per contract was in the HSE’s Western Administrative Area, with up to 10 applications being received for each vacancy. By contrast, posts in the South of the country received a maximum of 2 applicants per post. Applicants for the post of Assistant with a view to Partnership are lower than those for a full contract: vacancies in 2008 attracted a maximum of two applicants in most regions, with some vacancies in the area of Dublin Mid-Leinster not attracting any at all.⁶²
- 2.65 The inflexibility of the current GMS contract and, in particular, the requirement that GPs undertake to provide a full-time service to public patients on their list, is likely to prove unattractive to many GPs and may go some way towards explaining the fall-off in the numbers applying for contracts.

⁶¹ This is a rough estimate, based on an assumption that “non-GMS” agreements accounted for 10% of all HSE agreements with GPs in 1982. This would be in line with the trend in the years for which a breakdown between GMS and non-GMS agreements is available.

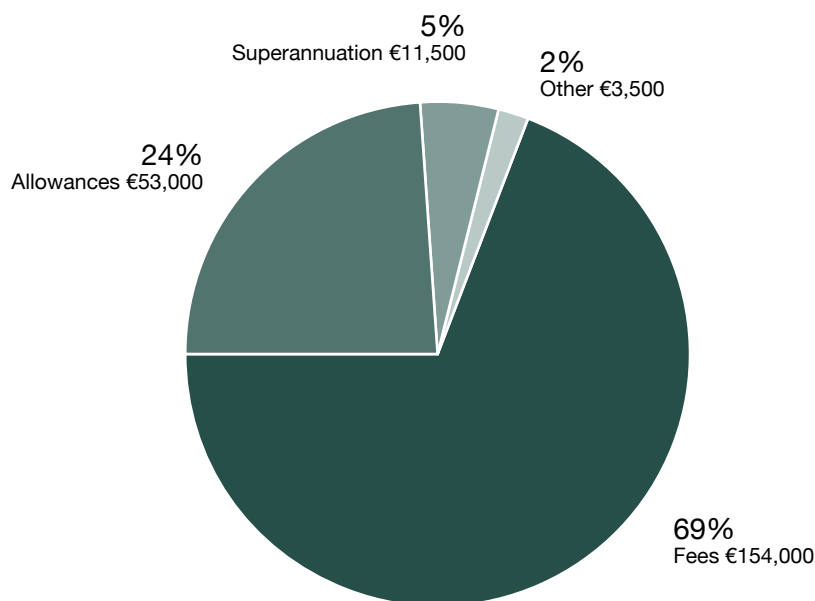
⁶² Source: HSE.

- 2.66 There is some evidence that GMS contracts are increasingly difficult to fill in rural areas and in certain deprived urban areas.⁶³ An ICGP Conference in 2008 noted that 35% of GP practices in the HSE Dublin North-East Region and 34% of practices in Dublin Mid-Leinster were closed to new patients.⁶⁴

GP incomes

- 2.67 The income of GPs in Ireland is derived from a mixture of payments from the State (for public patients) and fees-for-service (from private patients).
- 2.68 For most GPs, a substantial part of their income will come from the State in respect of services provided to public patients under the GMS scheme. In 2008, GMS-contracted doctors received an average of €220,000 under the scheme. (This figure includes payments received in respect of patients treated by non-contracted GPs working within the practice of a GMS-contracted GP.) Figure 2.9 shows that the bulk of payments made to doctors under the GMS relate to capitation fees and other fees for services provided to patients (69%).
- 2.69 About a quarter (24%) of the monies received by doctors under the GMS scheme are in the form of allowances for practice support services, such as secretarial and nursing support. Contributions to the doctors' superannuation fund account for a further 5% of payments, equivalent to €11,500 per doctor in 2008.

Figure 2.9: Average payment per doctor under the GMS, by type, 2008
(Total average payment per GMS-contracted GP, 2008: €220,000)



Source: HSE.

Note: Allowances include payments for secretarial/nursing support, allowances for locum hire to cover annual leave etc., and rostering/out-of-hours payments. 'Other' payments include salaries and benefits for retired District Medical Officers etc.

63 FÁS, *Healthcare Skills Monitoring Report*, 2005.

64 ICGP Annual Conference 2008, Address by Dr. Mark Walsh. www.icgp.ie.

- 2.70 Trainee GPs are employees of the HSE and hold contracts of employment. In the first two years of their GP training, they are employed in hospital House Officer (HO) posts on a basic salary scale of €41,177 - €58,374 depending on experience. Their salary is supplemented during these first two years of training by overtime payments, which are in some instances quite significant. The amount of overtime worked by trainee GPs varies, depending on hospital location and on the medical specialty involved. In years three and four of their training, trainees are placed in practices with GP Trainers, but continue to be treated as employees of the HSE. They are paid on the Non-Consultant Hospital Doctor (“NCHD”) Registrar scale of €53,869 - €64,384.⁶⁵ In addition to their basic salary, trainees receive a range of supplementary allowances during these final two years, which amount to over €18,000 per annum. These allowances include a payment of €11,427 per annum to reflect the loss of overtime once trainees move into clinical practice. The remainder is made up of travel allowances (€3,800 p.a.) and living-out allowances (€2,808 p.a.).

Conclusion

- 2.71 This chapter has highlighted a number of important features concerning the demand for, and supply of, GP services in Ireland.
- 2.72 On the demand side, decisions to visit the GP are clearly price-sensitive. Patients who have to pay the full cost of GP fees themselves have a considerably lower number of GP visits than those for whom GP fees are free or subsidised. This is true even when differences in the age profile, socio-economic profile and health status of the different groups are taken into account. The cost of visiting a GP has risen rapidly in recent years, significantly outpacing the general rate of inflation in the economy. There are indications that a substantial number of private patients are delaying GP visits due to cost factors and are “shopping around” for cheaper consultation fees. Government policy to increase the role of primary care and move treatment away from hospital-based, secondary care is likely to increase the demand for GP services in the years ahead.
- 2.73 On the supply side, a number of different issues have been identified:
- Changes within the GP profession, including the feminisation of the workforce, an increase in part-time working and a movement towards earlier retirement, mean that more GPs will be needed in the future simply to deliver existing levels of service;
 - The number of new GPs qualifying in Ireland is dependent on the number of GP training posts available in a way that was not the case in the past. New GPs must complete four years of specialist training in general practice, in addition to their medical degree;
 - The number of doctors qualifying in Ireland is set to rise in the years ahead following reforms in the system of medical education and training. In order for this increase in the overall supply of doctors to translate into growth in the number of specialist GPs, increased access to GP training programmes will be required;
 - Three out of every four GPs in Ireland are contracted by the HSE to provide services to public patients under the GMS scheme. Participation in the GMS scheme provides GPs with an important source of income (averaging €220,000 per GMS-contracted GP in 2008) and a range of significant ancillary benefits, including superannuation and practice support payments. The availability of GMS contracts has a significant influence on the location of GP practices throughout the country, and on whether GPs choose to set up in practice on their own or to join an existing practice.
- 2.74 The impact of some of these supply-side issues is discussed in Part II of this Report (Chapter 4) where we outline proposals to ease restrictions on entry to GP training programmes and facilitate more doctors to train as GPs.

65 Salary scales effective September 2008. Source: www.dohc.ie/publications/pdf/salary_scales_sept2008

3. REGULATION OF GENERAL PRACTITIONERS

- 3.1 This chapter describes the regulatory environment within which GPs operate and the professional bodies which represent them. A key feature to emerge is the significant, and growing, role played by the Irish College of General Practitioners (“ICGP”) in the training and accreditation of Irish GPs. In recent years the ICGP has assumed important regulatory functions (delegated to it by the Medical Council), which have served to place it centre-stage in any discussion of the GP profession in Ireland.

Representative bodies for GPs

Irish Medical Organisation

- 3.2 The Irish Medical Organisation (“IMO”) is a professional representative body for medical practitioners. The organisation represents four distinct Specialty Groups: Consultants, Non-Consultant Hospital Doctors, Public Health Doctors and GPs. The IMO is recognised as a trade union under the Trade Union Act 1941. It has over 5,800 members, over a third of whom (2,080 members) are GPs.
- 3.3 The principal objectives of the IMO are:
- To secure the organisation of persons engaged in medical practice;
 - To procure and ensure the maintenance of just and reasonable terms of employment, proper remuneration and to promote the honour and interest of the medical profession;
 - To regulate relations between members and employers, between members and members, and between employers and employees;
 - To negotiate with parties on behalf of its members on all matters pertaining to the practice of medicine; and,
 - To promote or oppose legislation pertaining to the practice of medicine.⁶⁶

Regulatory bodies for GPs

Medical Council

- 3.4 The medical profession in Ireland is regulated by the Medical Council. The role of the Medical Council is to protect the interests of the public in its dealings with registered medical practitioners, including GPs.⁶⁷
- 3.5 The Medical Council was established under the Medical Practitioners Act 1978 and commenced operation in April 1979. A new Medical Practitioners Act was introduced in 2007 and provides the legislative framework for the work of the current Medical Council.
- 3.6 There is at present no legal protection of the title “General Practitioner”. Anyone who is registered with the Medical Council as a medical practitioner can call themselves a GP. The Medical Practitioners Act 2007 provides, however, that the Minister for Health and Children may at some stage in the future introduce regulations to designate the title of GP. Such a move may be initiated by the Minister following consultation with the Medical Council, or pursuant to a recommendation of the Council.

⁶⁶ Source: IMO Constitution and Rules.

⁶⁷ There are a small number of exceptions under which a non-registered person may practise medicine. These are set out in Section 38 of the Medical Practitioners Act 2007.

- 3.7 The composition of the Medical Council is set out in the 2007 Act. The Council has 25 members. The Act specifically requires that nine of the nominees “*are not, and never have been, a medical practitioner*”. These include the six ministerial nominees, plus the nominees of the Royal Irish Academy, the Health Information and Quality Authority and the Independent Hospitals Association of Ireland. A further ten nominees are required under the Act to be registered medical practitioners. Strictly speaking, the remaining six members of the Council may, or may not, be medical practitioners. The expectation is that, in the case of four of them - the two nominees of the Health Service Executive (HSE), the nominee of An Bord Altranais and the nominee of the Health and Social Care Professionals Council – they will not be medical practitioners, thus giving a “non-medical practitioner” majority on the Council.
- 3.8 The current Council will hold office for the period 2008-2013. Its composition is set out in Table 3.1 below.

Table 3.1: Composition of the Medical Council 2008-2013

Medical Practitioners (12)		Non-Medical Practitioners (13)	
Number of Members	Nominating Body	Number of Members	Nominating Body
1	Irish College of General Practitioners	1	An Bord Altranais
1	Irish Psychiatric Training Committee	1	Health & Social Care Professionals Council
1	Royal College of Physicians	1	Health Information & Quality Authority
1	Royal College of Surgeons in Ireland	1	Independent Hospitals Association of Ireland
1	University College Dublin	1	Minister for Education & Science
1	University of Limerick	1	Royal Irish Academy
6	Registered Medical Practitioners elected from the Medical Register	2	Health Service Executive
		5	Minister for Health & Children

Sources: Medical Practitioners Act 2007, www.medicalcouncil.ie

- 3.9 The objective of the Medical Council is to protect the public by promoting and ensuring high standards of professional conduct and professional education, training and competence among registered medical practitioners.⁶⁸

Its main functions are:

- To ensure a high quality of undergraduate education of doctors;
 - To ensure a high standard of postgraduate training of specialists, including GPs;
 - To establish and maintain an updated and accurate register of doctors;
 - To establish disciplinary procedures;
 - To provide guidance on the professional standards of medical practitioners; and
 - To provide guidance on the ethical conduct of medical practitioners.
- 3.10 The Medical Council is funded exclusively by the annual payments of registered doctors. On 1 January 2009, there were 19,078 doctors registered with the Council.

Irish College of General Practitioners

- 3.11 The Irish College of General Practitioners (“ICGP”) was established in 1984 as a voluntary body to provide professional support for GPs. This support takes the form of education, training and research services.
- 3.12 Since the mid-1990s, the role and functions of the ICGP have increased significantly. The extension of the role of the ICGP came about initially in response to EU Directive 93/16, which facilitated the free movement of doctors, by providing for the mutual recognition of diplomas, certificates and evidence of formal qualifications. The ICGP qualification was listed for the purpose of the Directive as Ireland’s standard for GP qualification. Around the same time, the State began to award points to doctors applying for GMS contracts if they held an ICGP qualification.⁶⁹ In recent years, the Medical Council has delegated a number of important regulatory functions to the ICGP. The introduction of new rules on GP registration in Ireland, pursuant to the Medical Practitioners Act 2007 (see 3.20 below) has further consolidated the role of the ICGP in this area.
- 3.13 At this stage, the ICGP not only occupies a central role in the development and provision of education and training programmes for GPs; it is also responsible for setting the standards for training GPs and is the only body recognised by the Medical Council for the accreditation of specialist training in general practice in Ireland.

⁶⁸ Medical Practitioners Act 2007.

⁶⁹ Applicants for GMS contracts are assessed on their merits, with points awarded for qualifications, experience, etc. See Chapter 6 for details.

- 3.14 The College now effectively controls the gateway for those wishing to become a GP, albeit at the discretion of the Medical Council:
- Any doctor who wishes to train as a GP in Ireland must apply to the ICGP for inclusion on an ICGP-approved training course.
 - Since March 2009, any Irish-trained GP who wishes to be included on the Register of Specialist GPs must be a member of the ICGP.
 - The question of whether ICGP qualification is to become a necessary requirement for the award of GMS contracts is currently under consideration. As noted above, applicants for a GMS contract have, for some time, been awarded points if they hold an ICGP qualification. The establishment of the new register of GP specialists raises the question as to whether GMS contracts will in time be confined to those doctors registered as GP specialists. This would mean that only GPs holding an ICGP qualification would be eligible to apply for a State contract.
- 3.15 Applicants for membership of the ICGP must satisfy a number of criteria:
- They must be registered as a GP Trainee on the Trainee Register of the Medical Council. Doctors who occupy an approved GP training post on an ICGP programme are eligible to apply for registration on the Trainee Register;
 - They must pass the Membership in General Practice Examination (MICGP) examination. This examination is the end-point evaluation of the four-year GP training provided by the ICGP; and
 - They must also provide a Certificate of Satisfactory Completion of Training (“CSCT”).
- 3.16 Doctors who receive their GP training outside Ireland can apply for membership of the ICGP based on “equivalent qualifications”. The College recognises GP qualifications obtained in the EU and has a reciprocal agreement with the Royal Australian College of General Practitioners. Other applications for membership based on “equivalent qualifications” are dealt with on a case-by-case basis. The criterion used is that the training and assessment should be equivalent to the type and standard of General Practice training in Ireland.
- 3.17 The ICGP is a private organisation set up and run entirely by GPs. The powerful role of the ICGP in controlling access to GP training would normally raise concerns. A number of safeguards exist however, which reduce the likelihood of an abuse of power:
- The Medical Council remains the ultimate authority on matters to do with GP registration;
 - The Medical Council has the legal authority to revoke the regulatory powers of the ICGP at any time and appoint another body to carry out those functions or perform them directly itself; and,
 - The Medical Council, as noted above, is statutorily required to have a majority of members who are non-medical practitioners.

Registration of GPs

- 3.18 All medical practitioners who wish to practise medicine in Ireland are required by law to be registered with the Medical Council.⁷⁰
- 3.19 Under the old (1978) Act, the Medical Council maintained two registers: the General Register of Medical Practitioners and the Register of Medical Specialists. The latter was a voluntary register for medical practitioners with an approved specialty, who already held a full registration with the Council. The names on it overlapped, therefore, with the names on the General Register. Although GPs were entitled to seek to be included on the Register of Medical Specialists, in practice very few of them did so.
- 3.20 A new system of registration came into effect in March 2009, pursuant to the Medical Practitioners Act 2007. Under the new system, the Medical Council will maintain only one register of medical practitioners. The register is divided into four distinct divisions:
- Specialist Division: The Medical Council has designated General Practice as a “Recognised Medical Specialty”. GPs that have completed specialist training in General Practice recognised by the Medical Council are eligible for inclusion on the Specialist register. In the case of Irish-trained GPs, applicants must “have completed a recognised programme in General Practice and (must) also be a member of the ICGP”.⁷¹ On 1st September 2009, the number of doctors registered as “Specialist GPs” in Ireland stood at 1,777. This number is expected to rise to about 2,000 by end-year.⁷²
 - Trainee Specialists: Doctors who are working in approved postgraduate GP training posts are registered as Trainee Specialists;
 - Visiting EEA Practitioners: This division lists established EEA doctors (i.e. those who hold ‘full registration’ or ‘general registration’ or equivalent in another EU/EEA State or in Switzerland) who wish to work in Ireland on a temporary and occasional basis; and
 - General Division: Medical Practitioners who do not fit into any of the above divisions will be listed in the General Division. GPs who have not completed approved specialist training in General Practice and who do not occupy an approved GP training post will be registered in the General Division and are not entitled to represent themselves as a GP specialist.

70 Medical Practitioners Act 2007. An exception is made for visiting EEA practitioners attending in an emergency.

71 www.medicalcouncil.ie

72 Source: Medical Council.

Registration of foreign-trained GPs

- 3.21 In order to practise as a GP in Ireland, all doctors must apply for registration with the Medical Council. In addition, foreign-trained GPs who wish to treat public patients in Ireland must obtain a Certificate of Specific Training/Acquired Rights (CSTAR) in General Medical Practice. The eligibility criteria for registration with the Medical Council and for CSTAR certification are virtually identical.⁷³

GPs who receive their GP training in another EU member state

- 3.22 GPs who train in another EU Member State can apply to the competent authority in their own country for CSTAR certification under EU Directive 93/16. The Directive requires GPs to have a minimum of three years GP training in both hospital and clinical settings. Doctors who were in practice as a GP prior to 31 December 1994, or who had commenced a self-structured GP training programme prior to that date, can apply for CSTAR certification by virtue of “Acquired Rights” under EU Directive 93/16.⁷⁴ All GPs in possession of CSTAR certification are legally entitled to practise as a GP throughout the EU (including Ireland) and are eligible to apply for a State contract to treat public patients.
- 3.23 Possession of CSTAR certification entitles a GP to apply for a State contract. It does not, however, imply that the training and qualifications of such applicants are necessarily equivalent to that of an Irish-trained GP. Applicants for State contracts are assessed on their merits, with points awarded for qualifications, experience, etc. Irish-trained GPs will often have an advantage in this regard, due to the fact that the length and structure of the GP training programme in Ireland exceeds the minimum standards set down in the EU Directive.

GPs who receive their GP training outside the EU

- 3.24 GPs who obtain their qualifications, training or experience outside the EU can apply to the Medical Council for CSTAR certification. The Medical Council will typically refer such applications to the ICGP for consideration on a case-by-case basis. Such referrals are made at the discretion of the Medical Council and the final decision on eligibility rests with the Council.
- 3.25 The Medical Council can grant temporary registration to an overseas-trained, qualified GP from outside the EU, so that he or she can be employed and/or receive further training in Ireland. Applicants are required to pass a Temporary Registration Assessment Scheme (TRAS) which examines a candidate’s medical knowledge, clinical judgement and language proficiency.
- 3.26 In reviewing applications for CSTAR certification from GPs who trained outside the EU, the ICGP applies the following criteria:
- GPs must have completed a recognised GP Training Programme of a minimum three years;
 - They must have one year’s full-time experience in a GP practice in Ireland, including six months in a GMS practice; and
 - They must have successfully completed the MICGP examination, or a recognised equivalent.

⁷³ The main difference relates to the cut-off date for the possession of Acquired Rights under EU Directive 93/16. In the case of the Medical Council Register, the cut-off relates to 31 December 1996, whereas in the case of CSTAR the cut-off date is 31 December 1994.

⁷⁴ “Self-structured training” refers to doctors who organised their own training in general practice rather than follow a formal programme operated by an accredited provider.

- 3.27 The inclusion of the last two of the above conditions means that the criteria applied to non-EU applicants for CSTAR certification are more onerous than those applied to EU-trained GPs. The criteria are intended to ensure “equivalence” of the training and qualifications of Irish-trained and overseas-trained GPs. In cases where the training and/or experience of an overseas GP is deemed inadequate, the GP is required to retrain – either in their own country or by joining in at the start of the GP training programme in Ireland.

- 3.28 There are currently no options for recognising the “prior learning” or qualifications of experienced doctors who wish to set up as GPs in Ireland. If they fail to meet all of the criteria for CSTAR certification, they are effectively treated as though they were just out of their internship and have to complete the entire (four-year) GP training programme from the beginning.

- 3.29 Proposals to develop a “fast-track” programme which would allow doctors to receive credits for relevant experience/ qualifications are currently under consideration by the ICGP and the HSE. These proposals are discussed in greater detail in Part II of this Report.

- 3.30 There is a special arrangement in place for GPs who receive their GP training in Australia. Ireland and Australia have a reciprocal agreement in place which recognises the equivalence of GP training in the two countries. GPs who train in Australia can apply for membership of the ICGP through mutual recognition. This automatically entitles them to apply for registration as a GP Specialist in Ireland and entitles them to CSTAR certification. Australia is the only country to which this special recognition applies.

Foreign-trained GPs practising in Ireland

- 3.31 Data on the number of foreign-trained GPs practising in Ireland are very limited. Since entry on the Specialist Register of the Medical Council has until recently been voluntary, it is impossible to comment with any confidence on the number of overseas-trained GPs practising in the State. A recent report by FÁS suggests that approximately 5% of GPs practising in Ireland may be non-Irish nationals.⁷⁵ There is anecdotal evidence that such doctors may be disproportionately engaged in the provision of out-of-hours services. Without proper data, it is impossible to comment with any degree of confidence on this issue. The recent introduction of new provisions for GP registration should result in much improved availability of data on this issue.

- 3.32 In general, the level of international mobility among GPs might be expected to be lower than among other medical practitioners. This is because, for hospital doctors, overseas experience is seen as a prerequisite for career advancement. GPs, by contrast, are expected to develop strong links with the geographic area in which their practice is located, with close patient relationships built up over a period of time.

- 3.33 A second area where data are seriously deficient relates to the migration and emigration patterns of Irish-trained doctors. The number of doctors applying for GP training posts in Ireland far exceeds the number of posts available. Many of those who fail to secure a post in Ireland move abroad to receive their GP training (principally to the UK). There is no information available as to how many of these GPs subsequently return to set up in general practice in Ireland. In January 2009, the HSE launched a recruitment campaign in the UK to attract GPs to Ireland in a bid to address current and anticipated future shortages. Information on the impact or effectiveness of this campaign is not yet available from the HSE.

⁷⁵ FAS/Expert Group on Future Skill Needs, 2009, *A Quantitative Tool for Workforce Planning in Healthcare: Example Simulations*, June.

Part II

4. RESTRICTIONS ON THE NUMBER OF GPs QUALIFYING IN IRELAND

- 4.1 This Chapter examines an issue surrounding GP training that has historically impeded the number of GPs qualifying in Ireland each year. Currently all training programmes for GPs require that all trainees complete all four years of the programme - 2 years of hospital-based training with an off-site component ("Phase 1") and 2 years of GP practice-based training ("Phase 2"). There is no flexibility granted if a trainee already has completed equivalent relevant hospital training – they must repeat hospital-based training again once they get a place on a GP course.
- 4.2 The Competition Authority met the Irish College of General Practitioners (ICGP) in 2008 and highlighted the fact that the requirement to repeat training was costly, inefficient and ultimately was limiting the number of new GPs available to treat patients in Ireland. The Competition Authority proposed that an alternative intensive course – a "*Phase 2 Orientation Programme*" – could be introduced as a fast-track option for doctors who have completed relevant hospital-based training. It would allow doctors with prior relevant hospital-based training to proceed directly to the in-practice phase of GP training. This Programme would be equivalent to the off-site component of Phase 1 of GP training and provide doctors with appropriate knowledge and orientation for general practice. This proposal was deemed to be a workable solution by the ICGP and it has since sought funding from the HSE for the intensive course and Phase 2 training places.

GP training

- 4.3 Part I of this Report highlighted concerns that the supply of GP services may struggle to keep pace with the anticipated rising demand for GP services⁷⁶. To address these shortages, it will be necessary to increase the number of new GPs. This may be achieved by increasing the number qualifying in Ireland through ICGP programmes and/or by recruiting foreign-trained GPs.
- 4.4 The option of recruiting foreign-trained doctors with equivalent qualifications has some appeal in that it could provide a relatively quick, flexible and cost-effective way of addressing identified shortfalls in supply. In 2008, the HSE launched a campaign to recruit GPs from the UK. Information on the effectiveness of this campaign is not yet available from the HSE.
- 4.5 A second way of increasing the supply of GPs is to ensure that more doctors in Ireland receive GP training. Despite concerns that the future supply of GPs in Ireland will not be sufficient to keep pace with rising demand for GP services, an increasing number of qualified doctors who wish to train as GPs are unable to gain places on GP training programmes. In examining the imbalance between supply and demand for GP services, the Competition Authority identified an efficient way of tackling this imbalance by increasing the flexibility of GP training through a fast-track qualifying process for certain doctors. This new flexibility would enable more doctors to be trained as GPs in Ireland, in as efficient and cost-effective a manner as possible.

⁷⁶ ESRI Research Series Number 13, (October 2009), *Projecting the Impact of Demographic Change on the Demand for and Delivery of Healthcare in Ireland*, indicates that, by the period 2016-2021, 126 additional GPs will be required *each year*, simply to keep pace with the demand resulting from population growth and retirements. If the supply of GPs per head of population is to be brought into line with the EU average, the number of additional GPs required each year will need to increase further, to 201.

ICGP training programmes

Nature of the restraint

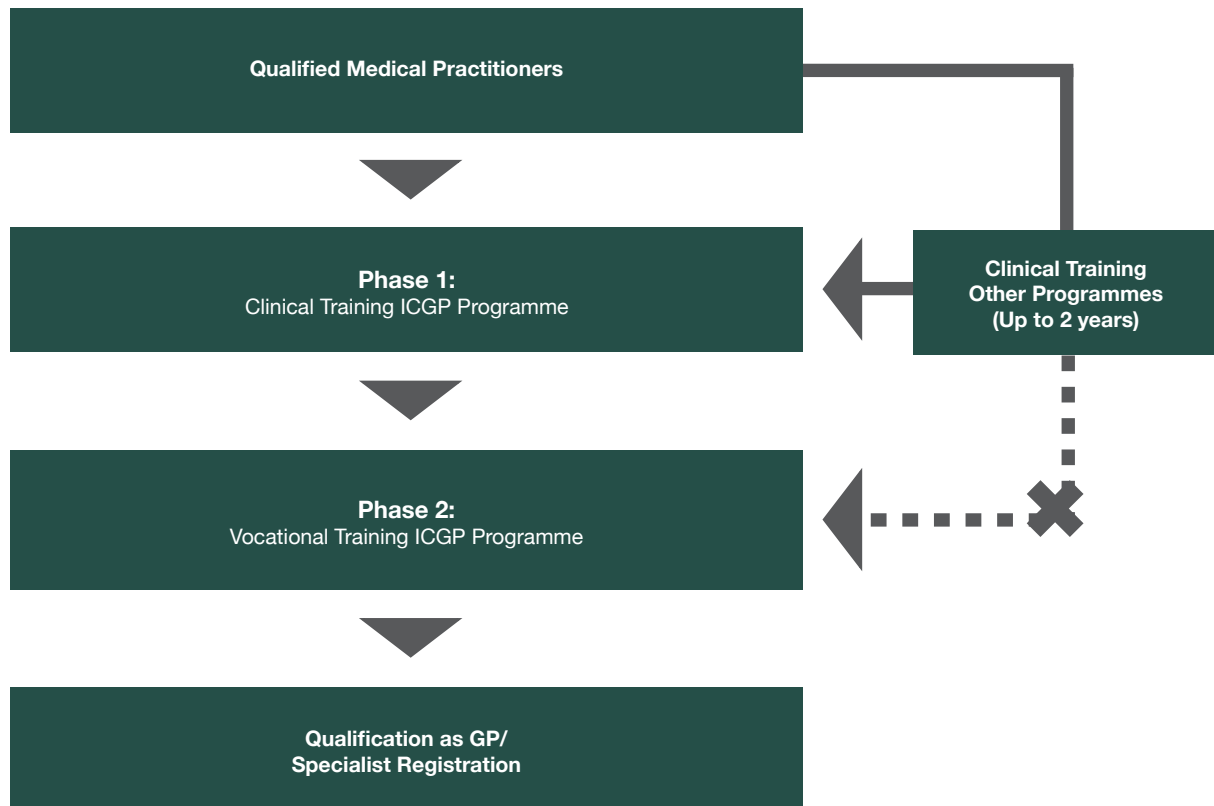
- 4.6 The crucial step for an aspiring GP wishing to train in Ireland is to gain a place on an ICGP-accredited GP training programme. There are thirteen ICGP accredited training programmes in different colleges and hospitals across the country.
- 4.7 As shown in Figure 4.1, ICGP training comprises two phases:
- **Phase 1:** two years of hospital-based training comprising four six-month “rotations” in areas of medicine relevant to General Practice, such as Paediatrics, Psychiatry, General Medicine, and A&E. Trainees attend a half-day workshop each week aimed at increasing their understanding of medicine outside the hospital setting; and
 - **Phase 2:** two years working under supervision as a trainee in a GP practice. This includes weekly full-day workshops outside of the medical practice.
- 4.8 It is important to note that post-graduate specialist GP training is “on the job”. Trainee GPs actively provide services to patients under the supervision of a consultant (within a hospital) or a trainer GP (in a GP practice), and receive a salary from the HSE during both phases of their training.

Figure 4.1 GP training: current model



- 4.9 Figure 4.1 shows the most direct path to becoming a GP in Ireland. Entry to an ICGP programme is on the basis of merit. In 2009 there were 360 applications received for 120 places. As demand for places exceeds the number of places available, some doctors will not gain a place immediately and may follow a different route, as discussed below.
- 4.10 Junior doctors who fail to get on an ICGP training programme at their first attempt may re-apply to the ICGP in subsequent years. They may in the interim take up posts as junior hospital doctors which are designated as training posts. This is known as “self-structured training”. Alternatively, a junior doctor accepted for training in another specialty programme may subsequently change their mind and wish to switch to General Practice.
- 4.11 Doctors who do not follow the direct route to becoming a GP, and who pursue alternative clinical training in the interim, have to start their post-graduate training again if they are subsequently accepted onto an ICGP training programme. Hospital-based experience gained while working in approved training hospitals, in positions equivalent to those held by GP trainees, is not recognised. Instead, the ICGP treats all new entrants into ICGP programmes as if they had entered the course immediately after qualifying as a medical practitioner (see Figure 4.2).

Figure 4.2: Current model of GP training: non-recognition of relevant clinical training



Effect of the restraint

- 4.12 The requirement to repeat training already completed extends the length of training for those doctors affected by the restriction (i.e. those switching from self-structured training or from another specialty training programme). This in turn delays and limits the number of new GPs available to treat patients in Ireland.
- 4.13 The failure to recognise relevant prior clinical training is costly to taxpayers (who must pay for doctors to repeat their training) and inefficient (in that it slows down the growth in the supply of GPs at a time when the demand for GPs is rising).
- 4.14 Government policy is to increase the significance and scope of primary care⁷⁷. Part I of this Report outlined significant potential shortages of GPs in future years. Unnecessary limitations on the number of qualifying GPs will exacerbate any existing, or future, gaps in service provision.
- 4.15 If the supply of GPs does not keep pace with the demand for services, patients are ultimately likely to suffer through:
- Reduced availability of GP services – for both private and public patients;
 - Higher prices to private patients to the extent that there is a shortage of supply; and
 - Increased pressure on A&E and out-of-hour services as patients look for alternatives to GP services.

Rationale offered for the restraint

- 4.16 GPs play a distinct and important role in the overall management of patient care. In particular:
- GPs must take a generalist approach to medicine – as opposed to the specialist orientation of secondary care within a hospital or other specialist clinical setting; and
 - GPs treat patients in the community rather than within a hospital or other specialist clinical setting.
- 4.17 Differences between General Practice and other specialties are reflected in the content of ICGP training. During the first phase of GP training, trainees attend a weekly half-day workshop focusing on primary care issues. Doctors in equivalent positions to ICGP hospital training posts, i.e. those in training programmes for different medical specialties or in self-structured training, do not attend these workshops.

Analysis of the Competition Authority

- 4.18 Ireland's requirement for GP services is likely to increase in the years ahead due, in particular, to:
- A growing and ageing population;
 - The changing nature of GP practices; and
 - Government policy to increase the role and scope of primary care.

It is important, therefore, that the supply of GPs is not unnecessarily restricted due to inflexibilities in the manner in which GP training programmes are structured.

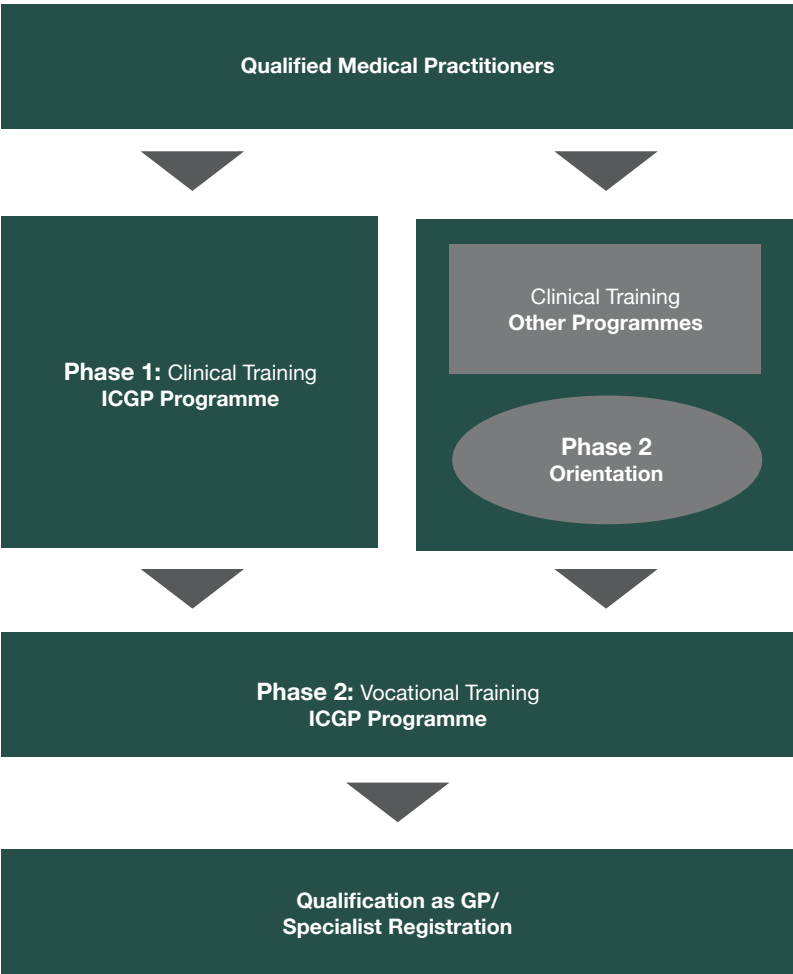
77 For further information see http://www.dohc.ie/publications/fulltext/primary_care_new_direction/

- 4.19 Non-recognition of relevant training already completed is inefficient and unjustifiable. It unnecessarily prolongs training for some doctors, with the effect that subsequent registration as a GP is delayed. The prospect of repeating rotations may also discourage potentially suitable doctors from applying to the ICGP in the first place.
- 4.20 It is appropriate that GP training should emphasise the community setting of GPs' work, as occurs now through the off-site component of Phase 1 training. However, the non-recognition of prior relevant training goes beyond what is necessary to ensure that GPs obtain this community-based focus. There are alternative ways to maintain standards for doctors who have completed relevant prior training, which do not require them to repeat hospital rotations already completed.
- 4.21 Non-recognition of prior relevant training, and the consequent requirement to repeat training, is out of line with the practice in other surgical or medical disciplines. Royal College of Surgeons of Ireland ("RCSI") programmes involve two to three years of rotation in basic surgical training ("BST"), after which the more in-depth and specialty-specific training takes place. Similarly, Royal College of Physicians of Ireland ("RCPI") programmes involve General Medical Training ("GMT"), also known as basic training, prior to specialty-specific training. As with the RCSI, junior doctors receive credit for any relevant training (i.e. hospital rotations in accredited service positions) undertaken prior to entry into any given training programme.
- 4.22 Non-recognition of relevant training and experience also appears inconsistent with the approach in other professions where there is a significant degree of specialisation. For example, recent reforms introduced subsequent to the Competition Authority's report on the legal profession have increased the ability of lawyers to switch between the barrister and solicitor branches of the profession.
- 4.23 For most of their time during clinical training, junior doctors in a GP training programme will be indistinguishable from junior doctors in other training programmes. It is not necessary that a junior doctor should repeat an entire clinical rotation in order to obtain the benefit of the half day off-site sessions which are part of the ICGP course. Rather, the "missing" primary care element could be addressed directly.

Competition Authority proposal: "Phase 2 Orientation Programme"

- 4.24 In 2008, the Competition Authority proposed to the ICGP that a short intensive course could be introduced to compensate for the off-site half day workshops in Phase 1 training. This would re-orientate doctors who have completed relevant hospital rotations in approved hospital posts to the generalist approach and community context of general practice (see Figure 4.3). The introduction of such a course would provide an avenue for increasing the number of GPs qualifying in Ireland at a faster pace and at a lower cost to the State than simply creating more Phase 1 training places.
- 4.25 This proposal entails an increase in the number of places available on Phase 2 of the GP training programme, with consequent funding implications for the HSE. The cost of increasing the number of GPs qualifying would be considerably less under this new system, however, than under the existing system. This is because of the savings achieved by eliminating unnecessary duplication of training in Phase 1.

Figure 4.3: Phase 2 recognition of relevant clinical training: Competition Authority proposal



- 4.26 Since the Competition Authority made the proposal to the ICGP, the ICGP has acknowledged that it is a workable solution and has sought funding from the HSE for the intensive course and Phase 2 training places. The ICGP's 2009 Annual Report stated;

*"One proposal put forward by the ICGP was the establishment of 'Phase 2 Training' which would provide for training in general practice over two years for doctors who had completed a self-structured, hospital based training in recognised training posts without the need for them to commence their Higher Professional Training de novo. Unfortunately this did not receive HSE approval as the proposal was not 'budget neutral'."*⁷⁸

- 4.27 The ICGP's Chief Executive, Fionan Ó Cuinneagain, also showed his support for this approach to training during a meeting of the Joint Oireachtas Committee on Health and Children, saying;

*"we have made a proposal to the HSE on what we call phase 2 training. This recognises any prior hospital training. If people had the appropriate level of hospital training, which is two years, under their belt they could then commence the two-year GP training directly. There would be some catching up because of the need to introduce them to general practice. It has not been possible to fund that. We are in discussions with the HSE about where we can go in terms of expanding the numbers. The HSE has acknowledged there is a need for expansion but it is not forthcoming, or cannot be forthcoming, with the funding."*⁷⁹

Benefits of proposed change

- 4.28 The number of new GPs Ireland produces each year is dependent on the number of places on ICGP training programmes. Currently the number of training places in Phases 1 and 2 are identical – with Phase 1 graduates taking up the majority of the places in Phase 2 (some places can go to graduates with equivalent qualifications from the UK, for example).

Prior recognition of relevant training, combined with an intensive orientation course, would:

- Allow the number of qualifying GPs per annum to be increased, by increasing the number of Phase 2 places without having to increase the number of Phase 1 places; and,
- Avoid unnecessary repetition of identical training.
- Increase the number of GPs qualifying in Ireland at a faster and more efficient pace
- Ultimately increase competition between GPs.

- 4.29 There is general agreement that implementing a "Phase 2 Orientation Course" would achieve these benefits. The issue of the funding of additional Phase 2 training places is a matter under discussion between the HSE and ICGP.

⁷⁸ Report of College Officers ICGP Annual Report, pg 5, 2009 available at http://www.icgp.ie/go/about/annual_reports/F681C6B8-19B9-E185-83F0001232386F9B.html

⁷⁹ Transcript on Joint Oireachtas Committee Health and Children, Thursday 12th January 2009.

5. RESTRICTIONS ON ADVERTISING BY GPs

- 5.1 This chapter examines the restrictions on GP advertising which until very recently significantly restricted competition and rivalry between GPs. Restrictions on advertising and the supply of information to patients prevented consumers from shopping around and impeded the development of price competition. The Competition Authority made a detailed submission to the Medical Council in October 2007, in which concerns about these restrictions were raised. The Medical Council subsequently removed the restrictions from the Council's updated ethical guidelines *Guide to Professional Conduct and Ethics for Registered Medical Professionals* (7th Edition) published in November 2009.
- 5.2 The removal of the restrictions on advertising will make it easier for consumers to obtain information about the availability and price of GP services in their area. They will also bring benefits to newly established GPs who want to advertise their entry into the market and should encourage GPs to offer new and innovative ways of delivering their service now that they can fully inform the public of any improvement.

Pre-2009 restrictions on advertising

Nature of previous restrictions

- 5.3 The Medical Practitioners Act 2007 specifies the general advisory functions of the Medical Council. These include that the Council shall:

*"Specify standards of practice for registered medical practitioners, including the establishment, publication, maintenance and review of the appropriate guidance on all matters related to professional conduct and ethics for registered medical practitioners."*⁸⁰

To give this guidance, the Council publishes *A Guide to Ethical Conduct and Behaviour*, normally every five years⁸¹. This Guide sets out ethical principles which doctors must apply to the clinical situations in which they work.

- 5.4 Section D of *A Guide to Ethical Conduct and Behaviour – Doctors in Practice* specified various limits on how doctors could operate as businesses, including the following:

- **Guideline 6.1 – Setting up practice** specified that registered medical practitioners who were setting up practice could only announce their presence by way of newspaper notices. Local radio announcements, flyers and other normal methods of creating awareness of a new business were not allowed. The details allowed included only the name of the doctor, the address of the practice, the opening hours and contact numbers. The guideline also specified that:

*"The announcement should not be inserted as a display notice. The notice should not measure more than 100mm in any direction."*⁸²

- **Guideline 6.2 – The internet** specified that if doctors wished to give details of their practice on the internet, the content of the site must be "non-promotional".

80 The Medical Practitioners Act 2007, available at <http://www.irishstatutebook.ie/2007/en/act/pub/0025/index.html>

81 *A Guide to Ethical Conduct and Behaviour* (6th Edition), available at http://www.medicalcouncil.ie/_fileupload/standards/Ethical_Guide_6th_Edition.pdf

82 *A Guide to Ethical Conduct and Behaviour* (6th Edition), Medical Council 2004 page 20.

- **Guideline 7.2 - Place of practice signs** stated that a professional plate and sign could only be displayed at the doctor's place of practice, containing the same information listed above in Guideline 6.1. No other signage was allowed. In addition:

*"If the practice is carried on in a business premises, the doctor's name may be included in a list of the occupants of the complex."*⁸³

- **Guideline 7.3 – Information for the public** identified a number of public places where information from a recognised postgraduate training body about the address of a doctor's practice premises could be exhibited or distributed. However such information:

*"should be restricted to the particulars mentioned in paragraphs 6.1 and 7.4, and should not contain comments about the doctor's personal qualities or expertise".*⁸⁴

- **Guideline 7.4 – Patient information** specified that, if a doctor wished to provide appropriate information for patients, including patient fees:

*"This is most suitable for display or distribution in the place of practice by the doctor or staff."*⁸⁵

- **Guideline 14.3 - Balance of benefit** stated that:

*"In adjudicating on complaints concerning doctors in the media, the Medical Council will consider whether the benefit to the doctor has been greater than that to the public and whether there has been an element of self-advertisement or a claim of possession of special skills, either of which could be interpreted as canvassing for patients. In all circumstances benefit to the patient must outweigh any incidental advantages to the practitioner concerned."*⁸⁶

Effects of the restraint

5.5 The restrictions on advertising as set out above had a number of distinct effects. By overtly restricting the content, format and location of advertising by GPs, the guidelines:

- Created barriers which unnecessarily inhibited GPs, either individually or jointly in a practice, becoming established. Advertising is an important way for new practices to make themselves known to potential clients;
- Favoured established GPs. Constraining the ability of GPs and/or medical practices, particularly those new to the market, to publicise their existence protected well-established GPs and/or medical practices from competition;
- Reduced the incentives for innovation on the part of GPs and/or medical practices. GPs and/or medical practices wishing to offer new or innovative ways of delivering services were restricted in how they could promote their new services and facilities. Consequently they were less able to attract new patients and recoup their investment;

83 *Ibid* page 20

84 *Ibid* page 21

85 *Ibid* page 21

86 *Ibid* page 28

- Discouraged price competition in the case of private patients. The restrictions made it extremely difficult for consumers to make price comparisons and ensure they were getting the best value. This allowed GPs to charge more than they would in a more transparent competitive environment; and
- Made it difficult for consumers to obtain information on the availability of medical services in their area. Consequently, consumers were less informed than might otherwise be the case about the options available and were hindered in their efforts to find the best option for them.

Removal of restrictions

- 5.6 In November 2009, the Medical Council issued new guidelines for Medical Practitioners entitled *Guide to Professional Conduct and Ethics for registered Medical Practitioners* (7th Edition). This followed a lengthy consultation period in which the Competition Authority made a detailed submission to the Council. The Authority's submission found that while asymmetric information and ethical concerns provide good reasons for regulating advertising, any guidelines and regulations should be effective and proportionate, i.e. should be well-targeted and should not unnecessarily restrict competition.⁸⁷ Limiting new practice announcements to newspaper notices of a maximum of 100mm (Guideline 6.1), or prescribing content and type of signage for plates (Guideline 7.2), did not benefit consumers. Rather, by restricting the availability of information, the guidelines benefited GPs and, in particular, well-established GPs who had less need to advertise for patients. The Competition Authority found that the guidelines were overly restrictive and disproportionate. They went beyond what was necessary to protect patients and they unnecessarily constrained competition.
- 5.7 The Competition Authority's submission also highlighted that distributing price information inside a GP's place of practice (Guideline 7.4) was of little benefit to existing patients and even less beneficial to consumers who either did not currently have a GP or who were considering switching from their current GP. Providing consumers with truthful information would enable them to make rational decisions that suit their needs, and should in fact reduce the risk of being exploited. Misleading advertising that exploits consumers is harmful but consumer protection legislation is in place to combat this. The Competition Authority pointed out that relying on established consumer protection legislation to deal with misleading advertising was a proportionate way of protecting the public.
- 5.8 Overall, the Competition Authority found that the Medical Council's *A Guide to Ethical Conduct and Behaviour* (6th Edition), included a strong presumption against advertising and against competition between GPs. This presumption gave rise to a set of disproportionate restrictions on advertising, which went beyond what was necessary to protect the public from misleading information. Accurate and informative advertising can have an important role to play in informing patients of available services and equipping consumers with the information they need to make rational decisions about their health, and their health choices.
- 5.9 The Competition Authority recommended that restrictions on the content, place and size of practice signs and advertisements be removed, along with restrictions on distributing price information.
- 5.10 In November 2009, new guidelines for Medical Practitioners *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (7th Edition) 2009, were published by the Medical Council. The Council implemented all of the recommendations to remove unnecessary restrictions and the Competition Authority welcomed their introduction at the time.⁸⁸

⁸⁷ The Medical Council had argued that that the purpose of the guidelines on advertising was to protect the public from false or exaggerated claims of special expertise and to ensure that the information distributed was not driven by commercial interests or personal advancement. The medical profession is particularly susceptible to this type of harm given that the consumer is far less knowledgeable about the service being provided than the practitioner (the "asymmetric information" problem).

⁸⁸ Press release available at http://www.tca.ie/NewsPublications/NewsReleases/NewsReleases.aspx?selected_item=263

- 5.11 In relation to the provision of information to the public and advertising, the new guidelines state that:

“The provision of information about the availability of medical services through the media, internet or other means is generally in the public interest provided that the information is factually accurate, evidence-based and not misleading.”⁸⁹

- 5.12 The guidelines go on to say that medical practitioners may advertise their practice by “*publicising the name and address of the practice, the practice hours and contact details*”. Doctors may also include their area of specialty, but if they consider publishing information further than this, doctors must “*make sure that the information published in the advertisement is true, verifiable, does not make false claims or have the potential to raise unrealistic expectations*”.

Benefits of the 2009 guidelines

- 5.13 The new guidelines are an important step in improving competition within the profession, and represent a very positive approach towards promoting the ease with which consumers obtain information on the availability and price of medical services in their area. This may lead to more competitive pricing now that consumers are in a better position to shop around.
- 5.14 The new guidelines also bring significant benefits to newly established GPs who want to advertise their entry into the market. In the past new GPs were limited in the extent of promotion they could carry out, only being allowed to advertise in newspapers on a one-off basis. It could therefore take a new GP a considerable period of time to build up a patient base, when depending solely on word of mouth. With the introduction of the new guidelines, newly established GPs are in a much better position to attract patients - particularly those that have been looking for a practice in a more convenient location or those simply wanting to change GPs. The removal of this barrier to entry is significant in the context of the need for more qualifying GPs as identified in Part I of this Report. It should encourage more GPs to set up practice, and again increase competition in the profession.
- 5.15 The restrictions on the content, size and location of advertisements have been lifted, and GPs are now allowed to advertise as they wish provided the information is factually true and verifiable. This new approach is likely to encourage innovative and creative ways of advertising, and it should lead to GPs adapting the way they deliver their services more fully to their consumers’ needs, now that they are able to promote any improvements.
- 5.16 The introduction of the new ethical guidelines has lifted a key factor which was preventing the development of competition in the GP profession. It’s now up to GPs, and consumers, to make the new environment work to their mutual benefit.

89 A Guide to Professional Conduct and Ethic for Registered Medical Practitioners (7th Edition), Medical Council 2009 page 49.

Part III



6. THE GMS: WHAT IT IS AND HOW IT OPERATES

- 6.1 The GMS scheme provides GP services free-of-charge to public patients throughout the State.⁹⁰ Over one-third of the population (1.6 million people) qualifies for free GP visits under the scheme.⁹¹ The HSE pays privately-contracted GPs to provide the services in designated locations. In 2008, 2,098 GPs held a GMS contract.⁹² This represents three out of every four practising GPs in the country. Total payments to GPs under the GMS amounted to €500m in 2009.

History of the GMS

- 6.2 The GMS Scheme was introduced in 1972 to provide free GP services for public patients. The scheme replaced the previous Dispensary System, which dated back to the Poor Relief (Ireland) Act 1851. Prior to the GMS, general medical services for eligible persons were provided free-of-charge through District Medical Officers. Services were provided at a public dispensary where recipients had no choice of doctor.
- 6.3 The GMS scheme represented a radical new approach. It sought to facilitate treatment of public patients alongside private patients, and to allow public patients to choose their own doctor. In order to do this, the State contracted to purchase services for public patients from GPs in private practice.
- 6.4 The initial (1972) contract for services under the GMS scheme was on the basis of fee-per-item. GPs were paid an agreed sum for every service provided to public patients, including a fee for every individual GP visit. In 1989, following concerns about the escalating cost of the scheme, the scheme changed to a capitation-based system.

Purpose of the scheme

- 6.5 The objective of the GMS scheme is to ensure that public patients throughout the State have access to free GP services. The HSE acts on behalf of the taxpayer to purchase the necessary services from individual GPs. In doing so, it seeks to provide:
- **Access** to GP services for all public patients, regardless of where they live;
 - **Choice** of GP for public patients, wherever possible; and
 - **Value** for taxpayers' money.

Nature of the GMS contract

- 6.6 The GMS contract is set out in a series of letters and circulars issued by the Department of Health and Children.⁹³ The basic contract in force today dates back to the original 1989 capitation contract, amended to take account of various changes and agreements over the years.
- 6.7 The contract sets out the terms and conditions under which GP services shall be provided. GPs are required to provide *“all proper and necessary treatment of a kind usually undertaken by a general practitioner”*, including any *“preventative and developmental services”* which may be required.

90 Public patients are patients entitled to free GP services under a range of schemes operated by the State. Medical card holders account for the vast majority of such patients. Details of the various schemes in operation and the eligibility criteria relating to them are provided in Part I of this Report.

91 At end-December 2009, there were 1,478,560 medical card holders and 98,325 GP Visit card holders. Source: HSE *Annual Report 2009*.

92 A further 501 GPs, who do not hold GMS contracts, are contracted by the HSE to provide services under the Primary Childhood Immunisation Scheme, the Health (Amendment) Act 1996, Heartwatch and the Methadone Treatment Scheme.

93 See www.icgp.ie/go/in_the_practice/information_technology/egms for details.

6.8 Important features of the contract include:

- **Life-long contract:** The GMS contract is to all intents and purposes a contract for life. The HSE can only terminate a contract if a GP has been removed from the register of medical practitioners, is found to be “*of permanent infirmity of mind or body*” or reaches the mandatory retirement age.⁹⁴ GPs are free to terminate their contracts at any stage, subject only to giving a minimum notice of three months.
- **Patient lists:** GPs who are awarded a GMS post generally receive a list of public patients who are registered to receive GP services under the terms of the scheme. Payments to GPs under the GMS are linked directly to the size of his/her patient list. Public patients are not obliged to stay with the GP to whom they are allocated. They can choose to register with another GMS practice, provided there is one available in the area. The extent of switching is low, however, and the provision of a “ready-made” client base is a key attraction of the GMS contract for GPs.
- **Location-specific:** The GP undertakes to provide services for public patients within a defined geographical area. He/she is not free to move and take the contract to any other area.
- **Full-time:** The contract requires that GPs provide full-time cover for public patients. They must undertake to work a minimum of 40 hours a week and must provide full cover for out-of-hours services, either personally or through a deputising arrangement, such as participation in an out-of-hours co-operative.
- **Individual contracts:** The contract is held by the individual GP, not by the practice in which he/she is working.
- **Practice-wide scope:** In multi-partner practices, it is only necessary for one GP to hold a GMS contract in order for all of the GPs in the practice to treat public patients. Patients will normally not be aware whether or not the individual GP treating them holds a GMS contract. The important thing from their perspective is that the practice is able to treat GMS patients.

6.9 GPs engaged to provide services under the GMS are independent contractors. They are free to derive income from both public patients (under the GMS) and private patients (through fee income). There is no restriction on the extent of a GP's private practice. The maximum list size for a GP's public practice is 2,000 patients.

6.10 There is no restriction on the form of incorporation for GP practices. They are free to establish as sole operators, partnerships or as part of larger corporate entities.

94 Contracted GPs can have their contract suspended or terminated under Section 31 of the contract in the event of a serious disciplinary complaint. The retirement age for GMS-contracted GPs was extended from 65 to 70 in October 2009.

95 Occasionally GMS contracts are offered without an associated patient list.

Remuneration of GPs under the GMS

“Without the GMS contract, General Practitioners would see a dramatic drop in their practice income...”

Irish Medical Organisation (2009) Response to the Report of the Special Group on Public Service Numbers and Expenditure Programmes, p6.

- 6.11 In 2008, GPs received an average of €65 for every visit made by a public patient.⁹⁶ This figure is considerably higher than the average fee charged to private patients (€51 in 2010).⁹⁷ Both figures capture the total revenue generated in respect of GP consultations for public and private patients. They suggest that GPs in Ireland are more highly remunerated for seeing public patients than for seeing private patients.
- 6.12 GPs receive a variety of payments under the GMS:
- **Capitation payments:** GPs receive an annual payment for every public patient on their list, regardless of how many visits a patient makes. Payments are weighted to take account of patients’ age and gender and of the distance to their home from the GP’s surgery.
 - **Practice allowances:** Contributions are made towards the cost of providing *locum* cover for annual leave, study leave, maternity leave and sick leave. Grants are provided towards the cost of practice premises. Practice support allowances are provided to assist with the cost of hiring secretarial and nursing staff. These allowances vary according to the size of the GP’s list of public patients.
 - **Superannuation:** The HSE contributes to the superannuation fund of contracted GPs.
 - **Other fees and allowances:** GPs receive fees-per-item for a range of specified services, such as suturing and excisions. Additional payments are made to GPs in certain remote or rural areas where population densities do not support large practices.
- 6.13 The average payment per GMS-contracted GP in 2008 was €220,000. This figure represents the average income derived by the practice under the GMS. Many contracted GPs employ other GPs within their practices. GP “principals”⁹⁸ (who hold a GMS contract) are reimbursed for all public patients on their list, regardless of which GP within the practice treats them. Like any other business, they must pay staff costs (including the cost of GP employees) out of their total business income.
- 6.14 The composition of payments to GPs under the GMS was shown earlier, in Figure 2.9 (Chapter 2). The majority of payments (69%) relate to capitation fees and other fees for services provided to patients. About a quarter (24%) of the monies received by GPs relate to practice support allowances. Contributions to the GPs’ superannuation fund account for a further 5% of payments.

96 The figure of €65 per visit is a conservative estimate of the payments made to GPs under the scheme. Total payments to GPs under the GMS amounted to €459.5m in 2008. These payments were in respect of 1.35 million eligible patients. CSO survey data indicate that public patients visit their GPs an average of 5.2 times per annum. This equates to a total of 7 million GP visits, or €65 per visit. The HSE has separately estimated that in 2008 the cost of GP services to GMS patients was €353 per patient. Based on an average of 5.2 GP visits per annum, this equates to an average fee per visit of €68. Recently published aggregate figures for 2009 suggest that the payment per visit to GPs in 2009 remained unchanged at €65 per visit. Sources: HSE, Primary Care Reimbursement Services, *Statistical Analysis of Claims and Payments 2008*; HSE Annual Report 2009; CSO (2008) Health Status and Health Service Utilisation, Quarterly National Household Survey, Q3 2007.

97 Survey carried out by the National Consumer Agency, May 2010. See www.nca.ie for details.

98 A GP “principal” is the owner (or part-owner, in the case of multi-partner practices) of the practice.

Key players

- 6.15 The parties to the GMS contract are the HSE (as purchaser) and individual GPs (as service providers).
- 6.16 The HSE was established in 2005. It is responsible for overseeing the operation of the GMS contract, on behalf of the Minister for Health and Children.
- 6.17 The 1989 GMS contract grants extensive powers to the Irish Medical Organisation (“IMO”), which is a representative body for doctors. The contract stipulates that any changes to the terms and conditions of the contract require “*agreement between the Minister and the Irish Medical Organisation*”. The word “agreement” is important in that it makes clear that more than mere consultation with the IMO is required prior to deciding on any change. It means that no changes to the terms and conditions (including fees) of contracted GPs can be made without the agreement of the IMO.
- 6.18 The fact that the GMS contract (which is between the HSE and individual GPs) is itself contingent upon an agreement (or series of agreements) between the Minister for Health and Children and the IMO greatly increases the difficulty in framing recommendations for change. Any change in the GMS contract requires first that the IMO agreement be amended; this amendment must then be reflected in the GMS contract. What this means in practice is that, in order for any changes to be implemented, the IMO must agree to their implementation. The existence of this contractual relationship has been one of the key impediments to reform of the GMS.

Career options facing newly-qualified GPs

- 6.19 Newly-qualified GPs face a number of career options in Ireland. They can:⁹⁹
- **Join an established GP practice** as an assistant or sessional GP¹⁰⁰;
 - **Wait for a GMS post (with associated patient list)** to come up and set up in practice wherever that post is offered;
 - **Set up in private practice** either alone or with others; or
 - **Work as a locum**, deputising for GPs who are sick or on leave.
- 6.20 The majority of newly-qualified GPs work in existing practices, as an assistant (26%), on a sessional basis (22%) or as a *locum* (12%). Only 10% of newly-qualified GPs work as GP “principals”, either on their own or in partnership with others.¹⁰¹
- 6.21 Virtually all GPs in Ireland treat public patients.¹⁰² They do so under different conditions, depending on whether or not they hold a GMS contract. GPs who do not have a GMS contract are only entitled to treat public patients within the practice, and under the supervision, of a GMS-contracted GP.
- 6.22 22% of newly-qualified GPs surveyed by the ICGP have a GMS contract.¹⁰³ This figure is very low compared to long-established GPs, where the vast majority of GPs hold a contract.
- 6.23 GPs who choose to set up in practice without a GMS contract are restricted to treating private patients only.

99 These choices are based on a presentation by Dr. John Ball to the National Association of GP Trainees (“NAGPT”) Conference 2007. See www.icgp.ie for details.

100 Sessional GPs work regular sessions in one or more surgeries on a continual basis. Assistant GPs work within an individual practice, often in the hope or expectation that they may in time be offered a partnership in the practice.

101 Survey of new and establishing GPs carried out by the Irish College of General Practitioners (“ICGP”) in August 2009. Survey replies were received from 592 recently qualified GPs. The survey defines “newly-establishing GPs” rather loosely. The term appears to relate to any “recent graduates” of GP training programmes. The majority of respondents were aged between 31 and 36. Some of these may have graduated up to 6 years before. See www.icgp.ie for details.

102 Fewer than 4% of GPs operate private-only practices, and the number of such practices is falling. See O’Dowd T., O’Kelly M. and O’Kelly F., (2008), *Structure of General Practice in Ireland 1982-2005*.

103 ICGP survey *op. cit.* Most of the GPs surveyed had qualified as a GP within the previous two years.

104 In 2008, three out of every four practising GPs held a GMS contract. If only 22% of newly-qualified GPs hold a contract, this suggests that the figure for long-established GPs must be considerably higher than this average figure.

- 6.24 Setting up a private-only practice is not an attractive option for most GPs. Public patients account for more than 50% of all GP visits in the State. Without access to them, the newly-qualified practice immediately loses half of its potential market. In addition, the financial benefits payable to GPs under the GMS make it difficult for private-only GPs to compete on price with GMS practices.

Acquiring a GMS contract

- 6.25 GMS contracts are awarded by the HSE in three situations:

- Retirement, death or resignation of an existing GMS post-holder;
- Creation of a position as an Assistant with a view to Partnership within an existing GMS-contracted practice; or
- Creation of a new post.

- 6.26 New posts may be created in situations where the HSE, following consultation with the IMO, has identified a clear shortage of GP services for public patients in a particular area. The criteria used to determine whether a new post is required are:

- **Access:** Ensuring that all GMS patients in a given location have access to GP services;
- **Choice:** Ensuring that GMS patients have a reasonable degree of choice in selecting a GP; and
- **Viability:** Ensuring that “due regard is given to the viability of practices in the area”.¹⁰⁵

- 6.27 Existing GMS posts are occasionally suppressed, rather than being made available to GPs in search of a contract. Posts are suppressed where the HSE (following consultation with the IMO) believes that the patients of a deceased or retiring contract-holder can be adequately catered for by the existing GP(s) in an area. This typically arises where the patient list involved is so small that it is thought unlikely to be able to support a viable practice. In these circumstances, the patient list will be taken over by a GP already *in situ*, or divided out among the existing GPs in the area.

- 6.28 The IMO is centrally involved in all stages of the process governing the number, location and allocation of GMS contracts. The IMO is consulted on all decisions regarding the creation or suppression of GMS posts and a nominee of the IMO sits on the interview panel for all GMS positions.

- 6.29 GPs applying for a post in the GMS are assessed using a marking scheme and an interview process. Points are awarded for professional qualifications and research; GP training and hospital experience; general practice experience; and “general suitability”. Each of these four categories is accorded equal weight in the marking scheme.

- 6.30 In relation to general practice experience, the marking scheme awards more points to GPs who already hold a GMS contract than to those without a contract. GPs with a GMS contract are awarded 20 points for each year working in general practice. Non-GMS GPs with their own practices receive 15 points for every year in practice. GP Assistants are awarded 10 points per year. “General suitability” is assessed by means of an interview process.

- 6.31 In addition to the three routes for acquiring a GMS contract described above, a series of one-off entry agreements have been negotiated over the years between the HSE and the IMO. These agreements typically arise when the pressure on GP services for public patients rises due to a major increase in the number of medical card holders, such as happened with the introduction of medical cards for all over-70s. The most recent of these one-off agreements was announced in October 2009.

¹⁰⁵ Department of Health Circular on Entry to the GMS, Circular 3/96, 19 June 1996.

Satisfaction with the existing GMS system

6.32 The GMS system is of major significance for patients (as users), GPs (as service providers) and for the HSE (as purchaser). Each of these three parties views the scheme quite differently.

(i) Patients

“The GP is ... the most frequently consulted point of the health service with most interaction with other services and is the best rated service”.

HSE (2007) Insight 07: Health and Social Services in Ireland – A Survey of Consumer Satisfaction.

6.33 A national survey carried out by the HSE in 2006/2007 shows that patients are quite happy with the quality of care they receive from their GP. Survey respondents reported prompt access to GP services, with no significant difference in access for public and private patients.

6.34 High levels of patient satisfaction were recorded across a range of variables:¹⁰⁶

- 81% of GMS patients, and 86% of private patients, rated the care they received from their GP as very good or excellent;
- 78% of GMS patients, and 83% of private patients, felt that they were given enough time to discuss their medical concerns with their GP; and
- 82% of GMS patients, and 86% of private patients, felt that the main reason they went to their GP surgery was dealt with satisfactorily.

6.35 While these results are reassuring, they need to be set against other figures that suggest that access to GP services is under strain, at least in some parts of the country:

- One-in-three GPs limit patient registration due to an excessive workload;¹⁰⁷
- 44% of GPs feel there are not enough GPs to meet the needs of the area, particularly in the Dublin region;¹⁰⁸
- 34% of private patients and 23% of public patients were put off going to the GP because of limited opening hours;¹⁰⁹ and
- 17% of private patients and 22% of public patients did not feel that they were given enough time to discuss their medical/health problem with their GP.¹¹⁰

6.36 Private patients tend to be ignored in discussions about the GMS as, despite the fact that they constitute the majority of the population, the HSE is not directly charged with addressing their needs. There is no official monitoring of their requirements or concerns. The implicit assumption is that “the market” will take care of such patients. Because private patients lie outside the scope of the GMS, they are generally thought to be unaffected by the operation of the system. This is not the case. In most cases, private patients themselves are unaware that their visits to GPs are affected in any way by the operation of the GMS system.

¹⁰⁶ HSE (2007) *op. cit.* The survey was researched and compiled by UCD and Lansdowne Market Research based on a nationally representative sample of people who have used the HSE's hospital and community services. A total of 3,517 people were interviewed during the period November 2006 – March 2007.

¹⁰⁷ IMO survey of GPs (2009), unpublished.

¹⁰⁸ IMO survey, *op. cit.*

¹⁰⁹ HSE survey (2007), *op. cit.*

¹¹⁰ HSE (2007), *op. cit.*

- 6.37 The GMS system has important implications for both the cost and availability of GP services for private patients. It impacts directly on the commercial behaviour of almost every GP practice in the State, affecting decisions on where GPs locate, the number of GP practices established, the nature of such practices and the profitability of individual practices. This in turn affects the provision of services for private patients and indirectly influences the fee GPs charge to private patients.
- 6.38 The biggest concern for private patients is the cost of GP consultations. Private patients pay up-front for every GP visit.¹¹¹ GPs are free to set the fee for private patients at whatever level they choose. The average cost of a GP visit for private patients is €51, with prices ranging from €35 - €70 across the country.¹¹² There is growing evidence that a significant number of private patients are delaying GP visits due to concerns about the cost involved.¹¹³ Price is not an issue for public patients because they are eligible for free GP visits under the terms of the GMS.
- 6.39 One specific area where private patients can be directly affected by the GMS system is where they become eligible for a medical card due to a change in their personal circumstances. A small number of these patients will have to change GP if they wish to avail of their new medical card, because their existing GP practice does not have a GMS contract. Approximately 4% of all GP practices in the country fall into this category of private-only practices.

(ii) General Practitioners¹¹⁴

“Possession of a GMS list is regarded by GPs as important in the successful long-term development of a practice, particularly in rural areas.”

Irish Medical Organisation (2009), Response to the Report of the Special Group on Public Service Numbers and Expenditure Programmes, p5-6.

- 6.40 GPs’ perceptions of the GMS differ depending on whether or not they hold a contract.
- 6.41 For established GPs in possession of a GMS contract, the main concerns relate to the level of payments received under the GMS (in particular, the threat of future cuts in payments) and the coverage of the contract in terms of the services they provide to public patients:¹¹⁵
- 82% of GPs believe that the current GMS contract provides value for money to the State;
 - 71% of GPs do not believe the contract caters adequately for the range of services patients require. Chronic care and preventative medicine were identified as areas in particular need of development. The Irish College of General Practitioners (“ICGP”) has also expressed its concern that the GMS contract fails to encourage “whole patient management”, including disease prevention and health promotion;
 - 73% of GPs do not believe the current contract supports high quality general practice.
- 6.42 For GPs without a GMS contract, restricted access to GMS contracts is the main point of concern. There is broad agreement among GPs generally that the terms of entry to the GMS should be changed, with 64% of all GPs surveyed by the IMO in favour of new terms of entry to the scheme.¹¹⁶

111 Tax relief on GP fees is available at the standard rate. Some private patients also receive relief on GP expenses under private health insurance schemes. See Chapter 2 (paragraph 2.12) for details.

112 NCA survey data May 2010. See www.nca.ie for details.

113 See Chapter 2 paragraph 2.25 and footnote 33.

114 Further details on the operation of the GMS, as it applies to GPs, are given in Chapter 2 (paragraphs 2.54-2.66).

115 IMO survey of GPs (2009).

116 IMO survey, *op. cit.* The survey was carried out prior to the announcement of the one-off relaxation of entry rules in October 2009.

- 6.43 Many newly-qualified GPs feel that the GMS system is biased against them. The following comments are typical of the nature of complaints made in the trade publications or received by the Competition Authority:

“The current system effectively restricts choice of medical practitioner to private patients, and ultimately discriminates against younger colleagues who wish to treat those with medical cards.... (It) discourages newly qualified GPs from setting up in areas where their services are badly needed.” Dr. Ruairi Hanley, Irish Medical Times, 20 May 2010.

“Why should a GP who opens a new practice not be entitled to treat any public patient that chooses to consult with them?” – Newly-qualified GP, West of Ireland, February 2010.

“It seems unreasonable to see GMS posts disappear when there are a number of establishing GPs actively seeking these posts in the area.” – Group of recent GP graduates, Mid-West Region, May 2010.

“The HSE and the Minister will not permit me to even apply for a GMS contract... I must not only turn medical card holders away from my practice, but I must send my own patients to other doctors who enjoy this privileged relationship with the HSE, as soon as my own patients become eligible for a medical card... As the public are now aware that I “am not allowed” to see medical card holders at my practice, there is a perception amongst locals that I am an inferior doctor, or that my practice does not meet the standards of the HSE. This further compounds the bias and anticompetitive nature of the HSE’s relationship with favoured established GPs”. – County Dublin GP, June 2010.

(iii) Health Service Executive

- 6.44 The HSE would like to see radical changes in the GMS system. It has advocated a move towards a system of competitive tendering for GMS contracts. The idea of competitive tendering was endorsed in principle in the *Report of the Special Group on Public Service Numbers and Expenditure Programmes* (“The McCarthy Report”). It has been strongly opposed by GP representative groups, including the IMO.¹¹⁷
- 6.45 HSE difficulties with the existing GMS system centre on three interconnected issues. Resolving the first of these is seen as a prerequisite for successfully resolving the latter two concerns.
- **IMO agreement on change:** Any changes in the GMS contract must be agreed between the Minister for Health and Children and the IMO. There is a contractual basis for this agreement within the GMS contract itself.¹¹⁸ This puts the IMO in a very powerful position. We return to this issue in the next chapter, where we identify a number of competition-related concerns with the GMS scheme.
 - **Cost:** The HSE is anxious to contain the cost of GP services provided to public patients under the GMS, particularly in the light of current budgetary constraints.
 - **Service transformation:** The HSE would like to extend the range of services provided to GMS patients and would like greater flexibility in service provision.
- 6.46 There is much common ground between the HSE and GPs in terms of the nature of GP services which might be provided under a reformed GMS system. The cost of such service provision remains a serious stumbling block.

¹¹⁷ See *Report of the Special Group on Public Sector Numbers and Expenditure Programmes*, Government Publications, PRN A9/0988, July 2009 and IMO response to same, available on www.imo.ie.

¹¹⁸ Clause 41(1) of the 1989 GMS contract states that the contract is “contingent upon” an existing agreement between the IMO and the Minister for Health and Children. It further states that the terms of any changes in the terms of the IMO agreement will be incorporated into the GMS contract. It would appear from this that the only changes that can be made to the GMS contract are changes that reflect those made in the IMO agreement.

7. COMPETITION-RELATED CONCERNS

- 7.1 Competition-related concerns about the GMS may be summarised under three headings:
- (i) Protection of established GMS practices;
 - (ii) Location-specific contracts; and
 - (iii) The role of the IMO.
- 7.2 The problems identified under each of these headings, and their overall impact on patients, are discussed below. Options for resolving these problems are outlined in the next chapter.
- 7.3 Some important concerns about the GMS relate to issues which lie outside the remit of competition policy. These include, for example, eligibility for services under the GMS and the question of universal access to free GP care; the nature and breadth of services provided to GMS patients; and the appropriate level of payment for the services provided. These issues are under active consideration in a number of different fora.¹¹⁹ The competition issues raised below should feed into, and inform, this wider debate.

Protection of established GMS practices

- 7.4 The GMS system of allocating lists of public patients to contracted GPs protects established GMS practices through:
- (i) **Barriers to entry** which restrict access to GMS contracts and make it difficult for newly-qualified GPs to set up in competition with existing practices;
 - (ii) The “**viability criterion**” used to determine the creation or suppression of GMS posts; and
 - (iii) The **marking system** used at GMS interviews, which favours GPs who already hold GMS contracts.

(i) Barriers to entry

- 7.5 Fully-qualified GPs, who have completed specialist training in general practice and are free to offer their services to private patients, are not entitled to treat public patients unless they have a GMS contract or work within the practice of a GMS-contracted GP.¹²⁰
- 7.6 Qualified GPs are not automatically entitled to apply for a contract to treat public patients. Intending applicants must wait until the HSE advertises a GMS post in a particular area. If they are successful in being awarded the contract, they must then set up practice in that location.¹²¹ Without a GMS contract, GPs who would like to set up a new practice, in competition with established practices, are restricted to treating private patients only.

¹¹⁹ See, for example, Second Report of the Joint Oireachtas Committee on Health and Children (February 2010), *Report on Primary Medical Care in the Community*.

¹²⁰ Strictly speaking, all GPs are entitled to treat public patients, but they will not be paid for treating public patients unless they hold a GMS contract.

¹²¹ The procedures for creating new GMS posts, and for assessing applicants for those posts, themselves contain elements which favour established GMS practices (see paragraphs 6.25-6.30). This reinforces the effect of the initial barrier to entry.

- 7.7 The system for awarding GMS contracts acts as a barrier to entry for newly-establishing GPs. It increases the difficulty of setting up a new GP practice in two ways:
- **Access to GMS contracts is restricted:** The HSE only awards a contract where a patient list becomes available (due to the death, retirement or resignation of the existing contract holder), or where a clearly-identified need for a new GMS post has been identified, following consultation with the IMO.¹²² A GP who wishes to set up in practice and treat public patients in an area of his/her choice may not be able to apply for a GMS contract, because there are no posts being offered in that area. In these circumstances, the GP may decide to set up in private practice. Without a GMS contract, however, the pool of potential patients available to his or her practice is immediately reduced by one-third.
 - **Competitors are subsidised:** The monies paid to GPs under the GMS effectively subsidise the entire practice, making it easier for practices which have one or more GMS-contracted GPs to compete on price for private patients.
- 7.8 Progress in opening up access to GMS contracts has been both slow and limited in scope. The Minister for Health and Children has indicated that she would like to see “*open access to GMS contracts for all suitably qualified and approved vocationally trained GPs*”.¹²³ Her success in doing so has been undermined, however, by:
- **One-off agreements:** Every amendment to the rules on entry must be agreed between the IMO and the Minister for Health and Children. Each change represents a one-off agreement: It applies only to those GPs who happen to fit the criteria agreed, on the specific date set down in the agreement. It does not change things for GPs coming after. In the absence of a more fundamental opening-up of the system, pressure for change will simply re-emerge in the future, as new GPs qualify and find themselves ineligible to apply for a contract under the existing rules.
 - **Continued protection of established practices:** Even where agreement has been reached on opening up access to GMS contracts, restrictive conditions in the rules on entry specifically prevent new entrants from taking on patients who are already registered with an existing GMS practice. This is clearly anti-competitive.
- 7.9 The recent relaxation of the rules on entry to the GMS, announced in September 2009, illustrates these points:¹²⁴
- Under the terms of the agreement, any fully qualified and trained GP who was in full-time general practice for a period of one whole year prior to 1 September 2009 was entitled to apply for a GMS contract.¹²⁵
 - GPs who obtain a GMS contract under the 2009 provisions are, however, initially only allowed to accept new medical card or GP Visit card holders.¹²⁶ In the case of GPs running their own practice, this restriction operates for almost four years (ending on 31 August 2013). For GPs in partnership with a GP who already holds a GMS contract the restriction applies for a shorter period of just under one year. The practical effect of these restrictions is to minimise the impact of new entrants on existing GP practices by limiting their ability to compete for public patients in the area.
- 7.10 The 2009 agreement on entry is a step in the right direction, but does not address the underlying constraints on competition. It has given a (limited) number of GPs the right to apply for a contract to treat public patients (although their right to compete for these patients with existing GP practices continues to be highly restricted). The “concession” awarded to GPs applying under the 2009 provisions is in reality very modest: GPs who obtain a contract under the 2009 agreement are not provided with a list of public patients. They are simply free to offer their services to the relatively small number of public patients who are not already registered with an existing practice.

¹²² Contracts are occasionally awarded outside of these circumstances as part of a one-off agreement reached between the Minister for Health and Children and the IMO.

¹²³ Letter from Department of Health and Children to HSE dated 30 September 2009.

¹²⁴ Letter from Department of Health and Children to HSE (30/9/09) setting out changes to the entry provisions to the GMS.

¹²⁵ Applicants had to be providing GP services “continuously at one location” during the period 1 September 2008 – 1 September 2009. This excludes, for example, GPs working as *locums* or sessional GPs who provide services in a number of different GP practices.

¹²⁶ “New” medical card holders are defined for this purpose as patients who become eligible for a medical card on or after 1 October 2009.

- 7.11 From the State's perspective, it does not make sense to restrict the number of GPs who are eligible to offer their services to public patients. In any market, reducing the number of eligible suppliers will tend to put upward pressure on costs. This is all the more likely where there is an overall shortage of suppliers (GPs) in the first place.
- 7.12 From a competition perspective, entry barriers always give rise to concern. Entry, and even the threat of entry, is what drives competition. New entrants in any business help to keep prices down, stimulate innovation and drive improvements in quality.

(ii) "Viability criterion"

- 7.13 The requirement that decisions on whether to create a new GMS post in an area give "due regard" to the viability of existing GMS practices in an area is clearly anti-competitive. It explicitly seeks to protect existing practices from competition by newly-qualified GPs. In effect, it gives existing GP practices in an area the right to influence the entry of new competitors in their locality.
- 7.14 The main situation in which a new GP practice would threaten the viability of an existing practice is if it was providing a better service to patients or offering a better price to private patients.
- 7.15 It is, of course, proper that the State should want to purchase GP services from a "viable" business. Problems arise, however, when ensuring the viability of a GP's practice becomes a goal in itself. The essence of competition is that some businesses will fare better than others. It is vital that they be allowed to do so.
- 7.16 The rules governing State contracts to community pharmacists used to contain similar "viability" considerations, which restricted the opening of new pharmacies in areas where there was an existing community pharmacist. These "viability" rules were removed in 2002, opening the way for increased competition among pharmacists, with consequent benefits for consumers.¹²⁷

(iii) Interview marking system for GMS posts

- 7.17 The marking system for applicants seeking a GMS post favours GPs who already have a GMS contract.
- 7.18 Existing GMS contract-holders are awarded 20 marks per year for their GP experience (up to a maximum of five years). Non-GMS GPs already working as principals in general practice receive 15 marks per year's experience, while GPs working as an assistant or continuous locum are awarded 10 points per year's experience.
- 7.19 This system means that, where a GMS post arises in a particular area, the incumbent GMS-contracted GP is placed at an advantage in applying for the new list. Consider, for example, three applicants: Each applicant is rated equally in terms of their professional qualifications and research, their GP training and hospital experience and their general suitability for the post. Each candidate has worked in general practice for a minimum of five years.
- Candidate A already holds a GMS list in the area. She has five years experience as a GMS principal and would now like to expand her practice by securing a bigger list.
 - Candidate B has been running a private-only practice in the area and wants a contract in order to be able to treat public patients in the area.
 - Candidate C has been employed as an assistant in a busy GMS practice and would now like to secure his own patient list.

¹²⁷ Under the *Health (Community Pharmacy Contractor Agreement) Regulations 1996*, it was expressly stated that a new pharmacy should "not have an adverse impact on the viability of existing community pharmacies in the area". In urban areas, new pharmacies could not open within 250 metres of an existing community pharmacy and entrants had to identify a population of 4,000 which was not served by the existing pharmacy. In rural areas, the minimum distance between pharmacies had to be at least five kilometres. These regulations severely restricted entry to the market, with negative consequences for consumers. The "viability" requirements for community pharmacies were removed in 2002, following representations from the Competition Authority. Further details are available in the *Submission of the Competition Authority to the Pharmacy Review Group*, December 2001.

Under the current marking system, Candidate A would be awarded the post, having secured 100 points, compared to 75 points (Candidate B) and 50 points (Candidate C). This reduces patient choice and limits the amount of competition between practices.

- 7.20 The manner in which GMS posts are created tends to favour working from the “inside”, through existing GP practices rather than by encouraging new entrants. Thus, if a GMS-contracted GP retires or dies, a decision may be made (following consultation with the established GPs in the area) to suppress the post. The GP’s patient list will then be divided between the existing GPs in the area, rather than being offered to a new entrant. Equally, if the HSE identifies a need for more GMS GPs in an area, existing contract holders may apply for an Assistant’s post in their own practice. If granted, this will have the effect of avoiding the creation of a new GMS post in the locality.

Location-specific contracts

- 7.21 The GMS system effectively seeks to divide up the market for public patients between participating GPs through the allocation of patient lists in specific locations throughout the State.
- 7.22 GPs applying for a contract under the GMS are not simply applying for the right to treat public patients; they typically apply for a list of patients in a particular location.¹²⁸
- 7.23 The extent to which the system grants local monopoly rights to contracted GPs is tempered by patient choice. The fact that public patients have a choice of doctors under the GMS allows an element of competition to develop between GPs at local level. This is a welcome and important feature of the system. In practice however, the scope for competition is curtailed because of patient inertia (which results in low switching rates) and because of restrictions inherent in the GMS system, which influence the number and location of GMS-contracted GPs throughout the State.
- 7.24 The GMS system encourages GPs to locate ‘where the lists are’ rather than where they see a business opportunity. This leads to inertia, sluggish responses to changing demographics, and a reduction in competition. In theory, new posts will be created for areas which are experiencing rapid population growth. In practice, however, the system actively curtails the creation of new practices, and favours working through existing practices wherever possible.

The role of the IMO

IMO role in fee-setting

- 7.25 The GMS contract provides for changes in the fees paid to GPs under the GMS to be made by agreement between the Minister for Health and Children and the IMO.
- 7.26 Collective negotiations by “undertakings”¹²⁹ on fees are prohibited by Section 4 of the Competition Act 2002 (“the Act”) and by Article 101 of the Treaty on the Functioning of the European Union. (It is the opinion of the Competition Authority, on the basis of legal advice, that GPs contracted to provide services to public patients under the terms of the GMS are “undertakings” for the purposes of the Act and thus fall within the remit of the Act.)
- 7.27 The reason for the prohibition on collective negotiation by undertakings is to protect consumers and the State from concerted practices by independent businesses which could result in them (ie. consumers and/or the State) paying higher prices than they would otherwise have to. In the current instance, the prohibition is intended to protect the State from paying excess prices for GP services purchased by the HSE.

¹²⁸ On occasion, contracts are offered without a patient list. This happened, for example, with the 2009 relaxation of the rules on entry to the GMS (see paragraphs 7.9-7.10)

¹²⁹ An “undertaking” is defined in section 3 of the Act as meaning “a person being an individual, a body corporate or an unincorporated body of persons engaged for gain in the supply of goods or the provision of a service”.

7.28 The principles at stake here are important and go to the heart of competition policy:

- Competition law protects consumers (and businesses) from collective action designed to force another party to negotiate with them. For example, in 2005, the Competition Authority accepted settlement terms offered by the Irish Dental Association (“IDA”) in proceedings taken in the High Court - following allegations that the IDA and its members engaged in a collective boycott of a private dental insurance scheme being introduced in Ireland by VHI Healthcare with a firm called DeCare. Consumers have benefited from the introduction of this dental insurance scheme in Ireland. This would not have happened if the Authority had not taken action to ensure that dentists set their prices independently of one another.
- This same protection exists for the Exchequer. For example, in 2009, the Government decided to reduce the fees paid to pharmacies for dispensing drugs under the community drugs schemes. It was aided in doing so by the protections of competition law. Pharmacists held a campaign of sustained pressure in an effort to force the Minister for Health and Children to reconsider the new prices. The Minister refused, supported by competition law which prohibited pharmacies from collectively negotiating their fees. Competition law thus helped protect the State and Exchequer from what might otherwise have been a successful attempt to resist fee reductions by pharmacists.

7.29 The recent *Hickey* judgement of the High Court sets out an approach to fee-setting which has been approved by the courts and which does not conflict with competition law.¹³⁰ It is recommended that this type of approach be adopted in any future changes to the GMS fees.

7.30 This approach allows the State to consult with representative bodies and/or their members on the fee structures for various State-operated schemes. Ultimately, the State unilaterally decides on a fee that it is willing to pay for the services provided. The Competition Authority has published guidance on similar models that enable health professionals providing services to the State to engage with the State on the matter of fees, while maintaining compliance with competition law.¹³¹

7.31 The GP profession already has experience of such models. In 2008, a model known as the “Messenger Model” was availed of to deal with the situation of setting fees payable to GPs for supplying services under the medical card scheme for the over 70s.¹³²

7.32 Messenger models and the “Hickey approach” provide a way for GPs to inform the Minister for Health and Children and the HSE of their costs and to give their views on fees, while ensuring that the State ultimately decides how much it is willing or able to spend on GP services. These avenues facilitate communication and exchanges of views while protecting the State purse from anti-competitive behaviour.

IMO agreement required on changes to other elements of the GMS contract

7.33 Under the terms of the current GMS contract, no changes can be made to the terms and conditions of the contract without the agreement of the IMO.

7.34 The GMS system is based upon two contracts: the GMS contract between the HSE and individual GPs and the Agreement (or series of agreements) between the Minister for Health and Children and the IMO. In order for changes in the GMS contract with GPs to be implemented, there must first be changes in the IMO agreement.

¹³⁰ *Hickey and others v HSE [2007]*, judgement of 11 September 2008.

¹³¹ Competition Authority *Notice in Respect of Collective Action in the Community Pharmacy Sector*, Decision No. N/09/001, 23 September 2009.

¹³² Under the messenger model, a third party (“the messenger”) would obtain from each service provider (ie. each GP), individually, the level of fees that he/she would require from the State to provide the services requested. The messenger would provide this information to the State, which would use it to devise a fee scale for the reimbursement of GPs that will secure the desired level of participation in the GMS. All communications between the messenger and individual GPs must remain confidential vis-à-vis other GPs, so that no GP knows what any other GP requires to participate. Each GP would then be offered a revised contract by the State, which the GP, again individually, may choose to accept or reject. For further details on the messenger model, see Competition Authority *Notice in Respect of Collective Action in the Community Pharmacy Sector*, Decision No. N/09/001, 23 September 2009.

- 7.35 The IMO, as a representative body for GPs, has a valid role to play in negotiating some elements of the GMS contract. However, the involvement of the IMO in the entire contract has resulted in its being in a position to agree to (a) collective bargaining on fees by the IMO, a practice which is prohibited by section 4 of the Act and Article 101TFEU, and (b) the insertion into the contract of a number of restrictions on competition. These are:
- Restrictions on access to GMS contracts;
 - Restrictions on location of GMS practices;
 - A requirement that regard be had to the viability of other GP practices in the locality when awarding a GMS contract;
 - The weighting in favour of those already holding GMS contracts of the marking system for awarding new GMS contracts
- 7.36 Contractual relations between the IMO and the Minister for Health and Children greatly increase the complexity of framing our recommendations for GMS reform. In effect, recommendations to remove anti-competitive restrictions in the GMS contract cannot be implemented without the agreement of the IMO.

Impact on patients

- 7.37 The restrictions on competition outlined above mean that:
- Fewer new GP practices are established;
 - Existing GP practices are protected from competition; and
 - The supply of GP practices in an area is slow to respond to demographic change and changes in patient demand.
- 7.38 Patients are adversely affected because there is:
- Less choice for patients;
 - Less incentive for GPs to innovate and develop their practices in order to attract new patients and retain existing patients; and,
 - Less competition for private patients, contributing to upward pressure on fees.
- 7.39 While public patients do not themselves pay for GP visits, the restricted pool of GPs paid to provide services to public patients limits competition for State funding.
- 7.40 The GMS system has a significant impact on the market for private patients. It affects the price private patients pay for GP visits, the supply of GP practices in their area and the level of competition among those practices.

- 7.41 The overall impact of the GMS on the price private patients pay for GP visits is unclear. This is because there are a number of opposing influences at work, some of which may work to reduce the price charged to private patients while others act to increase it:
- By boosting the overall profitability of GMS-contracted practices, the system may be subsidising the fees charged to private patients. GPs receive an average of €65 per visit for public patients under the GMS. This is considerably higher than the average fee charged to private patients (€51). GPs may in effect be using their income from the GMS to subsidise the cost to private patients.
 - Against this, the GMS system acts to reduce the number of new GP practices established, resulting in less competition for patients. This reduces patient choice and may contribute towards higher prices for private patients.
- 7.42 Despite the fact that private patients are clearly affected by the operation of the GMS, the system fails to take any account of their needs. The assumption is that “the market” will take care of their needs. This ignores the fact that the GMS system itself restricts the market from responding effectively to the needs of private patients.

8. PROPOSALS FOR GMS REFORM

Two models of competition

- 8.1 A number of competition-related concerns have been identified in this Report. These concerns can be addressed by modifying the existing GMS system or by moving to a new system of service provision, such as the competitive tendering model put forward by the HSE and endorsed in the McCarthy Report.¹³³
- 8.2 Different models of competition lie at the heart of these two options:
- **Competition in the market:** This involves GPs competing side-by-side for business. GP practices in Ireland already compete in this way. The extent of competition for both public and (indirectly) private patients is curtailed however by aspects of the GMS system highlighted in the previous chapter.
 - **Competition for the market:** This involves GPs (or others) competing for the right to provide GP services to designated populations and/or designated areas for a specified time period. The introduction of competitive tendering for GMS contracts would involve a major departure from the way in which GP services have traditionally been provided in Ireland.

Case for competitive tendering has not been made

- 8.3 The case for moving to a wide-scale system of competitive tendering is not clear.
- 8.4 Suggestions that Ireland move towards such a system are at a very early stage of development. Much work is needed to develop a clear picture of what such a system would entail, what it would mean for the provision of GP services throughout the country, and, crucially, what the impact on public and private patients is likely to be.
- 8.5 Appendix A seeks to move the debate forward by outlining the key features of a competitive tendering system and developing a preliminary assessment of its merits.
- 8.6 The benefits to patients of a move to competitive tendering are not clear. In particular, it is not obvious that the benefits for patients which may result from increased competition under a tendering system could not be achieved more easily, more quickly and more unambiguously by removing competitive restrictions within the existing GMS system.
- 8.7 We do not therefore advocate a move towards a wide-scale system of competitive tendering for GMS contracts. We favour instead changing the existing system of GMS contracts to allow competition to operate more efficiently within it.

Increasing competition within the GMS system

- 8.8 Table 8.1 summarises our key concerns about the existing GMS system, along with proposals to resolve them. The focus is on:
- Removing entry barriers;
 - Removing those aspects of the GMS system which favour established GP practices; and,
 - Reforming the procedures for implementing changes in the GMS.

¹³³ Report of the Special Group on Public Service Numbers and Expenditure Programmes, 2009.

Table 8.1: Solutions to address competition problems within the GMS system

Nature of concern	Effect	Solution
Protection of established GP practices: (i) Restricted access to GMS contracts Qualified GPs, who are otherwise suitable, have no automatic right to obtain a GMS contract. (ii) Viability criterion “Due regard” must be given to the viability of existing GP practices in an area before a decision is made to award a GMS contract in that area. (iii) Marking system for GMS interviews The marking system for GMS contracts awards more points to GPs who already hold GMS contracts than to GPs who have gained their experience in other settings.	These aspects of the GMS system combine to: Limit the number of GP practices. Encourage new GPs to operate within existing practices, rather than setting up in competition with them. Reduce competition for both public and private patients. Reduce the number of GPs entitled to offer their services to the State, adding to pressure on the cost and availability of such services. Favour existing GMS principals in the allocation of public patient lists.	Open up access to GMS contracts to all qualified GPs who meet general suitability criteria. Remove the “viability” criterion. Amend the marking system for awarding GMS contracts so that it no longer favours existing GMS contract-holders.
Location-specific contracts The GMS geographically divides up the market for public patients.	Creates quasi-monopolies at local level for incumbent GMS-contracted GPs	GPs in possession of a GMS contract should be free to set up in, or move to, the location of their choice.
Role of the IMO The GMS contract gives the IMO the power to fix, by agreement with the Minister for Health and Children, the fees paid to GPs under the GMS.	Allows collective negotiation of fees which is prohibited under Section 4 of the Competition Act 2002. Shifts power from the State (as purchaser) to the IMO (a representative body for GPs). May reduce State’s ability to secure value-for-money.	Payments to GPs under the GMS should be decided, not on the basis of agreement with the IMO, but <u>unilaterally</u> by the Minister for Health and Children, following (if desired) consultation with GPs and/or the IMO.

Impact of proposals

8.9 Removing restrictions on competition, as proposed above, would mean:

GPs

- All qualified GPs would be entitled to obtain a contract to treat public patients, subject only to meeting general suitability criteria. The contract would not guarantee them a patient list or any minimum income from the State. It would simply allow them to compete for public patients. Their success in attracting public patients would depend, as is currently the case with private patients, on how patients rated the services on offer.
- GPs would be free to choose where to set up in practice. They could move locations as required, in response to changes in supply and demand.
- GPs would have a greater incentive to deliver a top-quality service to patients and charge a competitive price to private patients. They would face a real threat of losing business if they failed to do so.

State

- The State would be able to draw on the greatest possible pool of GPs to provide services to public patients.
- The State (operating through the HSE) would decide the nature and level of service it wishes to purchase from GPs for GMS patients and the amount it is prepared to pay for those services. It could do this, if it wished, after consulting with GPs or the IMO, bearing in mind the need to ensure adequate GP services for public patients while at the same time working within budgetary constraints and securing value for taxpayers' money.

Patients

- Patients (public and private) would have access to the greatest possible choice of GP services.
- Private patients may benefit from increased price competition among GPs. This is most likely to occur where patients can choose between a number of different GPs, who are all competing to attract patients.

8.10 The proposals set out in Table 8.1 would involve two classes of GMS contract: with and without a patient list.¹³⁴

8.11 Under a system of open access, all GPs would be entitled to apply for a “basic” GMS contract, with no patient list. For newly-qualified GPs, this would increase the attraction of setting up in private practice.

8.12 Some newly-qualified GPs will be prepared to take their chances setting up in practice without a ready-made patient list. They should be allowed to make that choice. They will be competing, however, with GPs who have been given a list of public patients. Many GPs will feel that, in these circumstances, building a practice from scratch is not an attractive option.

8.13 GMS contracts which come with a patient list attached will, in most cases, continue to represent a more attractive proposition for GPs. The proposed opening-up of the GMS is unlikely therefore to lead to a radical jump in the number of GP practices.

¹³⁴ These two classes of contract already exist. Successive moves to relax the rules on entry to the GMS have created a number of contracts without a patient list.

9. RECOMMENDED CHANGES TO THE GMS

- 9.1 The first essential step in any strategy to increase competition among GPs must be to ensure an adequate supply of GPs. Competition will remain limited for so long as the demand for GP services continues to outstrip supply.¹³⁵
- 9.2 A second important step towards increasing competition is to remove unnecessary restrictions on the provision of GP services to public patients. We have identified a number of changes to the existing GMS system which would allow competition to work better for the benefit of both public and private patients.
- 9.3 Our recommendations for GMS reform are addressed to the Minister for Health and Children, the HSE and the IMO.
- 9.4 The recommendations fall into two categories:

A. The removal of rules which protect established GMS-contracted GP practices from competition from newly-qualified GPs.

Recommendation 1: Access to GMS contracts should be opened up to all qualified and vocationally trained GPs, who meet general suitability criteria.

Recommendation 2: GPs in possession of a GMS contract should be free to set up in, or move to, the location of their choice.

Recommendation 3: Decisions to award a GMS contract in a particular area should not be required to take account of the “viability” of existing GP practices in that area.

Recommendation 4: The marking system for awarding GMS contracts should be amended to ensure that applicants with similar levels of GP experience are awarded equal points and that applicants already in possession of a GMS contract are not treated more favourably.

B. Changes in the process for determining payments to GPs under the GMS.

Recommendation 5: Payments to GPs under the GMS should be decided, not on the basis of agreement with the IMO, but unilaterally by the Minister for Health and Children, following (if desired) consultation with GPs and/or the IMO.

- 9.5 Because the GMS contract (which is between the HSE and individual GPs) is contingent upon an agreement (or series of agreements) between the Minister for Health and Children and the IMO, all three parties (the Minister for Health and Children, the HSE and the IMO) must be involved in any reform of the system.¹³⁶
- 9.6 Any change in the GMS contract requires first that the IMO agreement be amended; this amendment must then be reflected in the GMS contract. What this means in practice is that, in order for our recommendations to be implemented, the IMO must agree to their implementation. The existence of this contractual relationship has been one of the key impediments to reform of the GMS. It may ultimately prove easier and more effective to terminate the existing contract and start afresh with a clean slate rather than seek to amend the existing contract.

¹³⁵ See Chapter 2 for a discussion of the shortage of GPs in Ireland.

¹³⁶ Individual GPs have agreed that any changes in the GMS contract should be negotiated by the IMO on their behalf.

Appendix



A. COMPETITIVE TENDERING FOR GMS CONTRACTS

Nature of a competitive tendering system

- A.1 The *Report of the Special Group on Public Service Numbers and Expenditure Programmes* (“The McCarthy Report”) recommended that:

“GPs should fashion their own specific contracts enabling the HSE to specify the services they require and to set a price acceptable and affordable in the light of the dramatically changed budgetary situation as well as enabling suppliers to compete to provide these services.”

- A.2 Under a competitive tendering system, the HSE would specify the nature and level of GP services it requires. Suppliers (be they GPs or intermediate corporate entities) would compete to win a contract to provide those services in a defined area, for a specific period of time.
- A.3 Neither the HSE nor the McCarthy Report offer any details of what a competitive tendering system for GP services would look like, how it might operate in an Irish context and how we might move from the current system to the new regime. In the absence of such detail, it is difficult to assess what the effect of competitive tendering would be and, in particular, how it would impact on public and private patients. It is useful, however, to consider the basic features of such a system.
- A.4 The idea for competitive tendering appears to come from the UK model of Primary Care Trusts (see box on page 75). There are, however, important differences in the context within which GP services are provided in the two countries:
- Lack of universal access to free GP services in Ireland; all patients in the UK are eligible for free GP care.
 - GP principals in Ireland are self-employed professionals operating independent businesses; GPs in the UK are employees of the National Health Service (NHS).
 - Patients have a choice of doctor in Ireland; In the UK, patients are more restricted in their choice of GP.
- A.5 A recent OECD report on healthcare reform points out that:¹³⁷

“the success or otherwise of any market-based initiative is likely to be highly contingent on the institutional and cultural setting within which it is implemented.”

There can be no presumption that what works in one country will work in the same manner in a different environment.

¹³⁷ OECD, 2009, *Achieving better value in healthcare*.

A.6 The OECD is cautious about the role of competition in healthcare markets. It points out that:

- Competition needs to be implemented with care. Markets can produce great instability, variations in performance and inequalities. These may be at odds with underlying principles of the health service, such as equity and comprehensive access to health care.
- Competition, on its own, cannot succeed in delivering health policy objectives. Other policy instruments need to be correctly aligned to give competition a chance of success. Key instruments include the financing mechanism, the performance management regime and entry and exit mechanisms.
- Effective use of market mechanisms requires considerable managerial skills and is likely to impose major transaction costs in purchasing and regulatory institutions.
- High-quality clinical outcome measurement (focused on patient care) must be implemented alongside any competitive regime.

A.7 The level of planning and administrative oversight required under a competitive tendering system should not be underestimated. It may prove to be far higher than the resources currently applied by the HSE to administer the GMS.

A.8 Effective performance management under a tendering system requires massive resources in collecting and evaluating information. The nature and scale of the information required may be gauged by considering the UK's performance management system. Any move to implement wide-scale competitive tendering for GMS contracts would require major investment in the upgrading of information and management systems within the HSE.

Model of Primary Care Trusts in England

The National Health Service (NHS) in England provides GP services through a system of Primary Care Trusts (PCTs). There are 10 regional Strategic Health Authorities (SHAs) in England, overseeing the performance of 152 PCTs.

Primary Care Trusts control 80% of the overall NHS budget. They purchase services from a range of primary care providers, including GPs, dentists, opticians and pharmacists. PCTs are responsible for ensuring that there are enough services for people in their area. They must make sure that all health care services are provided, including hospitals, mental health services, NHS walk-in centres, NHS Direct telephone service, patient transport (including accident and emergency) and screening. Their role is to get the health and social care systems in their catchment area working together for the benefit of patients.



Criticisms of competitive tendering: the IMO response

- A.9 Only 12% of GPs surveyed by the IMO believe that third party providers should be allowed to contract to provide GP services to the HSE.
- A.10 The main arguments put forward by the IMO against the introduction of competitive tendering for GMS contracts are that it would result in:¹³⁸
- **The corporatisation of primary care** and the dismantling of community practice;
 - **A reduction in the quality of patient care;** and
 - **Poorer value for money.**

(i) Corporatisation of primary care

- A.11 The IMO is opposed in principle to the corporatisation of primary care in Ireland. It sees corporatisation as a “bad thing”. It argues that allowing large medical corporations to become involved in the delivery of GP services will

“pit GPs against GPs and GPs against medical corporations in bidding wars for GMS contracts” and will “allow private companies with no experience in healthcare to operate services under the GMS... GPs will become mere employees”.

“Inviting tenders will force small community practices into competition with large corporately owned health care centres or clinics for the provision of services under the GMS”.

There will, it argues, be “*obvious tensions*” between “*the physicians’ role to act in the best interest of the patient and that of a commercial body whose prime interest is to make profit for their shareholders*”.¹³⁹

- A.12 Arguments against the principle of corporatisation are not persuasive:

- Corporatisation is already happening. The structure of general practice in Ireland has changed considerably in recent years; one of the changes has been a trend towards increased corporatisation. This is evident, for example, in the development of GP Cooperatives for the delivery of out-of-hours services and in the growth of neighbourhood medical care centres, which incorporate a range of primary care services including GP services. Most, but not all, of these new centres are owned and operated by medical practitioners. There are already instances where non-medical practitioners have set up GP practices to treat private patients, employing qualified GPs to deliver the services to patients.
- Patients have no inherent interest in who owns or operates their local GP surgery, except in so far as it impacts on the quality of care that they receive. Providing they receive the best quality care from a registered GP within the practice, it is likely that they will neither know nor care who the beneficial owner of the practice is.

¹³⁸ IMO Response to the Report of the Special Group on Public Service Numbers and Expenditure Programmes. www.imo.ie

¹³⁹ All quotations taken from IMO Response to the Report of the Special Group on Public Service Numbers and Expenditure Programmes, *op. cit.*, pages 5 - 6.

- Looking after patients' interests and making a profit are not necessarily mutually exclusive. Traditional GP practices have to reconcile these two objectives on a daily basis. There is no reason in principle why this should be any more difficult if the practice was owned and/or managed by a larger corporate body.
- There is a comprehensive regulatory system in place in Ireland to ensure that high standards of patient care are observed by doctors. The Medical Council is responsible for protecting the interests of the public in its dealings with medical practitioners, including GPs.¹⁴⁰

A.13 The debate about competitive tendering should not be reduced to a discussion of the pros and cons of the corporatisation of primary care. The trend towards corporatisation is happening already and is likely to continue to happen, regardless of whether or not there is any change in the manner in which GPs are contracted by the State under the GMS.

(ii) Quality of patient care

A.14 The IMO argues that a competitive tendering system would adversely affect the quality of patient care. Three broad areas of concern are identified:

- **Continuity of care:** There are concerns that patients would be forced to change GP under a tendering system, because some currently-contracted GPs would not be successful in retaining their GMS contracts. This could destroy patient/GP relationships which had been built up over many years and undermine effective patient management.
- **“Cream-skimming”:** The IMO argues that profit-driven corporate practices would focus on treating patients with relatively minor episodic illnesses, which can be dealt with quickly and cheaply. They would tend to avoid more complex cases which involved long-term, holistic patient management. Chronic disease management would suffer as a result.
- **Access to local services:** The IMO suggests that a competitive tendering system would give rise to large GP clinics which would require substantial catchment areas to survive. It suggests that these large clinics are unlikely to locate outside of the larger cities and towns in Ireland. Access to GP services at local level would be reduced. People in rural areas, and people without access to public transport, will suffer most as a result.

A.15 The suggestion that a tendering system would result in poorer access to GP services in local areas or allow companies to “cherry-pick” the most profitable aspects of patient care is not a criticism of tendering per se, but rather a reflection of a poorly-designed system. It would be the responsibility of the commissioning body (the HSE) to design a system which ensured adequate service provision in all areas of the country, and which specified clearly the care to be provided to patients by contracted GPs. If the contract is properly designed and enforced, it should not be possible for contractors to ignore parts of the country or select only the most lucrative aspects of patient care.

¹⁴⁰ See Chapter 3 for details of the regulatory system in place.

- A.16 Concerns about the continuity of patient care under a tendering system merit serious debate. There is a potential conflict between patients' desire to have a long-term, continuous relationship with their GP and the likelihood of changes of GP, under a tendering system. The essence of any tendering system is that tenders will be for a limited duration, and there will be penalties for non-performance. If the system is to have any practical effect, there must be winners and losers. The immediate losers in this case would be those GPs who failed in their bid to acquire or retain a contract. The indirect losers, however, would be the patients of those GPs, who must now switch to another doctor. The argument that these patients will be offered the services of a "better" GP (ie. a GP who won out under the tendering process) may not be convincing to those patients who have established a long-term relationship with their family doctor and would like that relationship to continue.
- A.17 An important attraction of the current GMS system, in theory at least, is that it places the patient (not the HSE) at the centre of performance management. Under the "choice of doctor" scheme, patients become the ultimate arbiter of performance. If, in the patient's view, a GP is not delivering a good service, he/she can choose to go elsewhere. This presupposes, crucially, that the supply of GMS-contracted GPs is such as to offer a genuine choice of doctor to patients in all areas. We have already indicated above that certain elements of the existing system restrict the supply of GMS-contracted GPs. This inevitably undermines the effectiveness of patient choice as an instrument of competition.
- A.18 From the patients' perspective, the introduction of competitive tendering could raise a number of concerns:
- Restrictions on individual choice of GP: under competitive tendering, patients may not have the right to form their own individual assessment of a GP's performance. GPs could lose a contract to treat public patients based on concerns about the performance of the wider corporate body, rather than due to any deficiencies in performance on their own part. The decision to register with a particular GP, or to change GPs, might no longer rest with the patient but could be made at a higher level, by the intermediary bodies and by the HSE.
 - Uncertainty and instability: most patients value the stability of a long-term relationship with their GP. They might not want that relationship to be up for review by a third party every number of years. They are likely to oppose a forced change of GP or the prospect of repeated changes of GPs over their lifetime.
- A.19 The above problems could potentially be avoided if failure to secure or retain a contract under a tendering system resulted only in a change of the administrative/managerial function, while leaving the actual service providers (GPs) unchanged. This system would appear to be more workable in a situation where GPs were employees of the HSE (thus providing them with some continuity and security of employment) rather than private undertakings.

(iii) Value for money

- A.20 The IMO asserts that the current “*independent contractor model of general practice ... provides ... value for money*”. No evidence is provided in support of this statement.¹⁴¹
- A.21 The McCarthy Report estimated that significant savings of the order of €370m per annum could be achieved by moving to a system of competitive tendering.¹⁴² Again, no details are provided of where or how these savings might be secured.
- A.22 It is not our role to determine whether the services provided by GPs under the GMS constitute “good value for money”. It is clear, however, that the desire to achieve cost savings is one of the factors behind the current debate on GMS reform.

Assessment of the Competition Authority

- A.23 Suggestions that Ireland move towards a competitive tendering system for GPs under the GMS are at a very early stage of development. Nothing is known yet about the details of how such a system might operate in Ireland. Much work is needed to develop a clear picture of what such a system would entail, what it would mean for the provision of GP services throughout the country, and what the impact on patients is likely to be.
- A.24 A number of concerns about competitive tendering have been identified. Many of these concerns appear capable of being addressed within the context of a carefully-designed tendering system. Certain issues of a more fundamental nature remain however. In particular, more debate is needed about how continuity of patient care can be ensured under a system of competitive tendering. It is also clear that competitive tendering would require very significant resources in terms of the information and management systems required to administer the system. It is not clear that such systems are currently in place.
- A.25 Competitive tendering could, in principle, assist in the resolution of several of the competition concerns identified in the previous chapter. Depending on how such a system was designed, it could remove the IMO from its position as power-broker for the GMS. It would remove any bias in favour of established GMS practices and would provide a market based mechanism for the allocation of public patient lists. It could be designed in such a way as to incorporate the needs of private patients.
- A.26 If competitive tendering is to be considered as a replacement for the current system of individually-contracted GPs, it is important that the objective of such a change is made clear. Is the objective to improve patient outcomes or control costs? If it is intended primarily as a way of controlling costs, there may be other options available to do this which yield better outcomes for patient care.
- A.27 The case for moving to a wide-scale system of competitive tendering is not clear. Much more detail on such a system is required before a final assessment of its merits can be made. Switching to such a system would be a major undertaking, which would take some considerable time to bed down. Reform of the GMS system is required urgently, so that the recent increase in the number of GP trainees can yield maximum benefits for patients.

¹⁴¹ IMO Response to the Report of the Special Group on Public Service Numbers and Expenditure Programmes, *op. cit.*, page 5.

¹⁴² The total monies paid to GPs under the GMS in 2009 amounted to €500m.

