3.4 Family Health Services

Primary care covers a wide range of services provided by a number of different health and social care professionals. It is an integral part of the whole system of care and is often the first point of contact for people who need help, support and advice from the health and social services.

There has been increased emphasis in recent years for primary care to take on more activity and direct fewer patients to other more expensive parts of the health & social care system. However, there is concern that that the resources required to facilitate this move have not been transferred. Concurrently, some of the clinical roles and responsibilities carried out by GPs are to be transferred to practice nurses, community pharmacists and other allied health professionals as part of a multi-disciplinary team, with more people being treated at home.

Family health services comprise: General medical, pharmaceutical, dental and ophthalmic services. The majority of expenditure is spent on the first two service areas; dental and ophthalmic services have not been covered as part of this Review. However it should be noted that the number of dentists and optometrists per head of population in Northern Ireland is the highest of the UK countries.

As in the rest of the UK, general medical services in Northern Ireland were delivered under the terms of the 1990 GMS contract. This allowed GP practices to operate a system of fundholding. While not all practices in Northern Ireland operated under fundholding, the majority did.

Under fundholding, individual GP practices were allocated a budget each year. Each practice controlled how this money was spent and what services were provided to their patients. Hospital costs for patients and practice staff costs were also met by each individual practice. Fundholders were also allowed to retain any savings made by the practice for reinvestment in future years.

There was a perception that fundholding contributed to an inequitable service. Following the abolition of fundholding in England and Wales and the establishment of Primary Care Groups (which evolved into Primary Care Trusts) a decision was taken to abolish fundholding in Northern Ireland. Fundholding was abolished in March 2002 and resulted in all GP practices being funded directly by Boards. Under the new system all hospital costs were also met by Boards as were practice staff costs and rents and rates of GP practices.

Local Health and Social Care Groups (LHSCGs) were established on the abolition of GP Fundholding. There are currently 15 LHSCGs based in local Trust areas and working across all areas of health and social care to address gaps in local service provision and to develop primary care services[52]. The Groups are required to develop links with their communities, all primary care stakeholders in their areas and other relevant agencies. It was envisaged that the LHSCGs would progressively receive larger budgets devolved from the health boards to allow them to develop a greater commissioning role[53].

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[52] However, under the recommendations from the Review of Public Administration the number of LHSCGs will need to be reassessed.
[53] *Building the Way Forward in Primary Care*, DHSSPS Consultation Paper, December 2000.

However, amongst the 60% of GPs previously operating as fundholders there was significant resistance to the abolition of fundholding and a reluctance to become involved in the LHSCGs. There were two contrary views expressed by the groups and individuals we met as part of the consultation process on this matter. One was that the lack of GP involvement meant that LHSCGs were unable to develop and take on greater responsibility for the commissioning of services. The other was that the lack of responsibility and funding meant that LHSCGs were a step back for GPs, and that as a consequence there would be little point in becoming involved. The issue of GPs' involvement in allocation/purchasing decisions is returned to in Section 4 as part of suggestions for improving the performance management system.

A new national GP contract was implemented in April 2004. Its aims were to reward practices for higher quality care, improve GPs working lives and ensure patients benefit from a wider range of services in the community. In addition the news GMS contract is expected to lead to a fairer system of funding as well as the overhaul and modernisation of ICT infrastructure. The contract was negotiated and implemented on a UK wide basis. he new contract resulted in a 25% increase in spend on primary care between 2003-04 and 2004-05 when the new contract was implemented. In the first year this increased investment has resulted in practices achieving a significant proportion of the quality targets which had been set.

The new contract also meant that GPs could opt out of the responsibility for securing the provision of out of hours services and this would then transfer to Boards. Most, if not all GPs opted out of this responsibility and Boards have been responsible for re-provision with effect from 1 January 2005. The cost of providing this service was estimated at £21m. GPs who opted out of this responsibility were required to pay back a proportion of their funding designed to provide services to their patients and this amounted to some £5.5m in 2004-05. There is a question here of why the fall in income was not more in line with the cost of providing the transferred services.

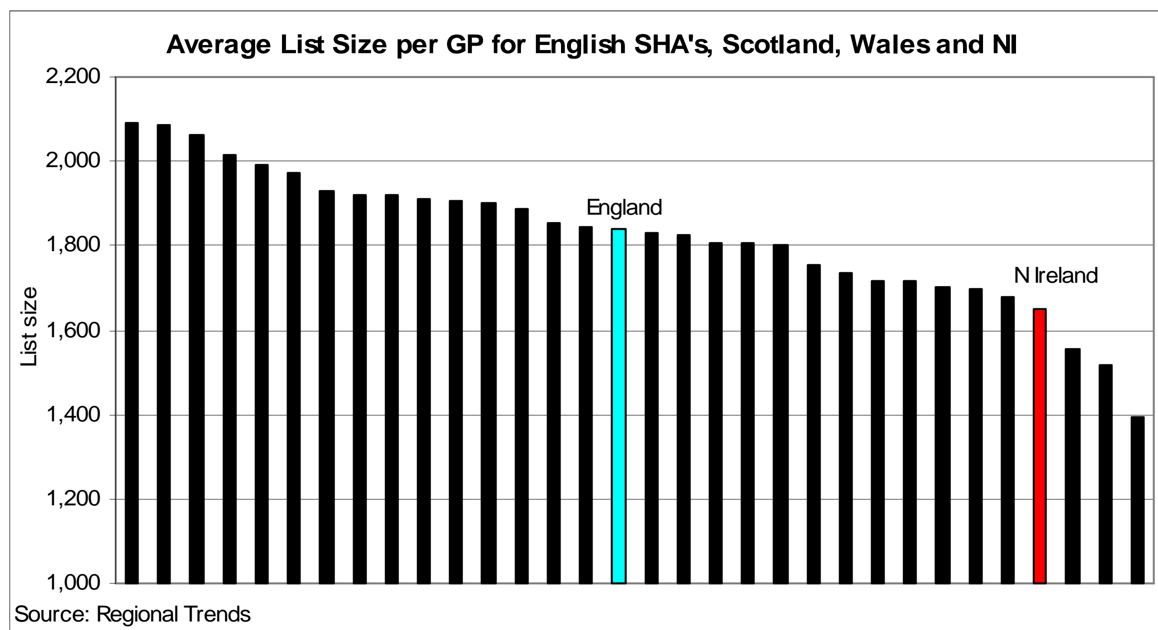
The new GMS contract delivers financial rewards for high quality care. The maximum quality points that can be achieved under the contract is 1050. In the original estimates for funding the contract, assumptions were made that approximately 75% of these points might be achieved but in practice GPs in Northern Ireland have achieved some 90%-95% of these targets which has resulted in an additional pressure of some £9m on the existing GMS contract envelope.

An important issue is that it is not clear that the better than expected performance in meeting targets reflects an improvement in quality of service or that the targets set were insufficiently challenging. If the former, then the ability of GPs to significantly improve quality outcomes in such a short period of time raises serious issues regarding past performance. DHSSPS have indicated that an objective of the new contract was to ensure that GPs are now remunerated for services they had previously provided in addition to their core terms of service but were not paid for. In other words, there was a 'deadweight' cost implicit in the new contract. However, it is unclear whether this phenomenon, common to many NHS employees, was significantly greater in respect of GPs.

There are currently around 1,100 GP's working in 366 practices in Northern Ireland. The number of GP's has increased by over a fifth in the past twenty years with the result that list sizes have fallen by over a tenth. Figure 3.14 below shows that GP list

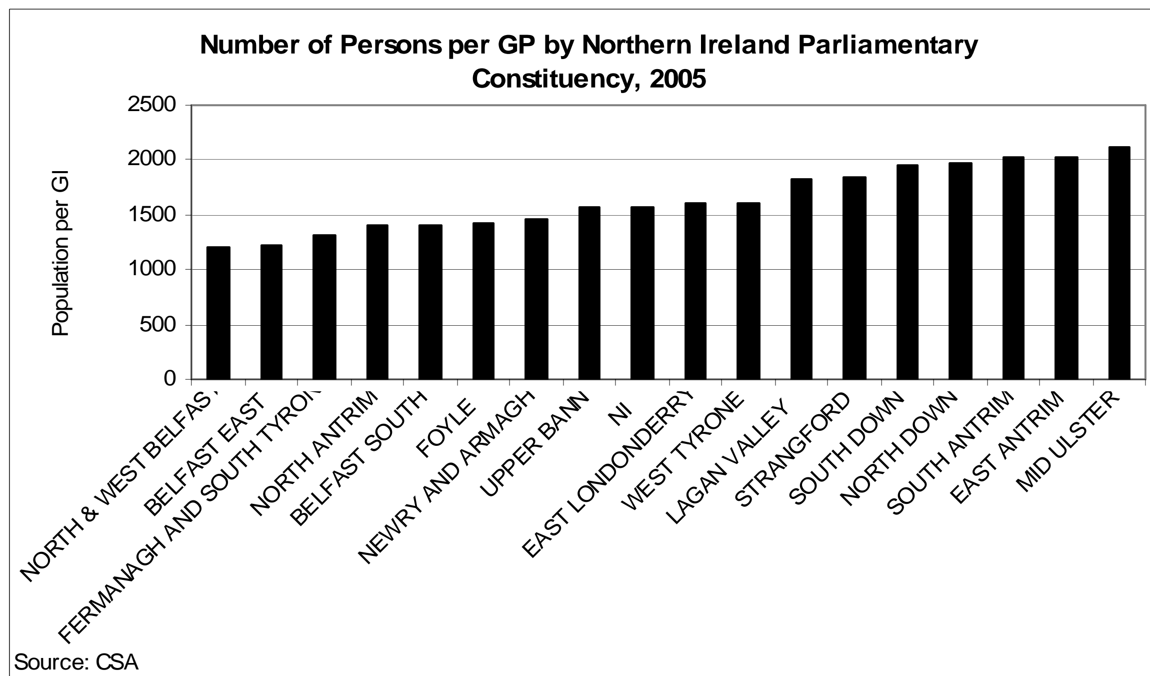
sizes in Northern Ireland are lower than the rest of the UK, with the exception of Scotland and the South-West of England.

Figure 3.14: GP List Sizes in Northern Ireland are 10% lower than in England, 2002



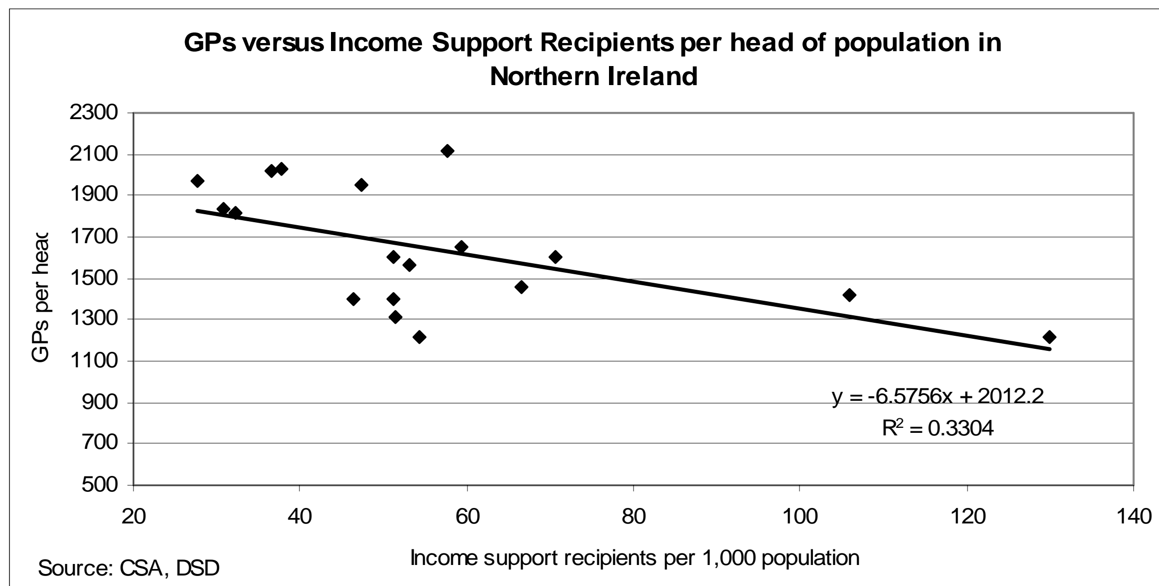
And figure 3.15 shows that there are significant variations within Northern Ireland in terms of the resident population per GP, with North & West Belfast having around 1,210 persons per GP compared to 2,110 for Mid Ulster.

Figure 3.15: The number of persons per GP is 74% higher in Mid Ulster than North & West Belfast



However, this appears to reflect the higher numbers of income support recipients - as shown in figure 3.16. The number of recipients is taken as an indicator of deprivation, and as those in deprived areas tend to have higher rates of illness it is assumed that they would require more attention per patient from GPs, necessitating smaller GP list sizes.

Figure 3.16: There is a negative correlation between Income Support recipients and GPs list sizes in Northern Ireland Parliamentary Constituencies .

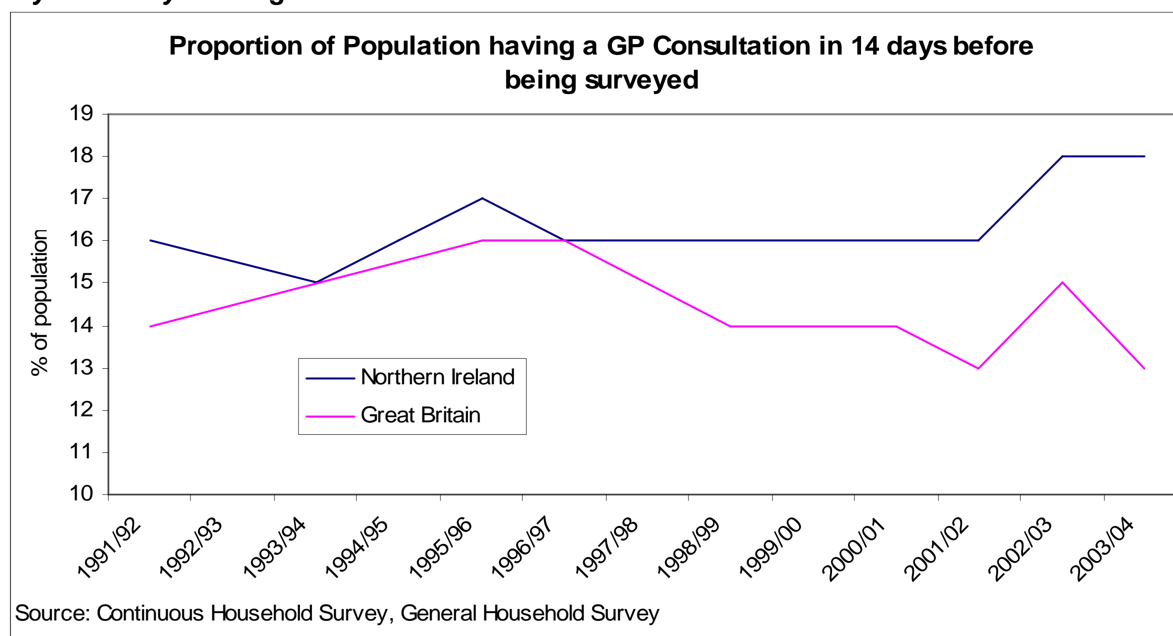


In terms of work load, whilst figure 3.14 shows that GP list sizes are smaller in Northern Ireland than in most other areas of the UK, the number of GP consultations per head of population is higher.

Figure 3.17 shows that 18% of the Northern Ireland population had a GP consultation in the previous 14 days compared to 13% in Great Britain. In addition, whilst there appears to be a general downward trend in GP consultations in Great Britain since the mid 1990's, this has not been replicated in Northern Ireland. This raises the question of whether the higher rate of GP attendance reflects a greater level of need, or that alternative forms of treatment might be more appropriate.

A recent survey of GPs carried out by the Central Services Agency found that 48% of respondents reported that their morale as a GP was low, whilst 93% felt that too much is being asked of general practice. And nearly half stated that they would sacrifice some income in order to have less work - of concern given the increasing roles that are being expected of GP practices, and in particular the implications of the new GMS contract (with which, only a fifth were satisfied). Almost two-thirds felt that patients receive better care in general practice than five years ago. Surprisingly, only 58% of GPs agreed that a GP in a deprived area has to cope with more pressures and stress than a GP in a less deprived area.

Figure 3.17: The Proportion of the Population having a GP Consultation in the previous 14 days is nearly 40% higher in Northern Ireland than GB



3.4.1 Prescriptions

One of the main issues of concern with the provisions of health & social care services in Northern Ireland has been the relatively high level of GP prescribing[54]. In response, DHSSPS have introduced a variety of initiatives including the Prescribing Incentive Scheme which encourages GPs to make more effective and efficient use of prescribing resources by rewarding practices financially for achieving savings – practices were allowed to keep up to 60% of savings achieved in 2004/05.

GP prescribing is routinely monitored by prescribing advisers in each of the Health and Social Services Boards. Their role is to engage with GPs to encourage safe, rational and cost effective prescribing. The main method of communication with GPs and practice staff is by practice visits aimed at:

- Agreeing actions related to prescribing
- Discussion of evidence of change in prescribing
- Responding to queries on prescribing

A key objective of prescribing advisers is to increase the level and appropriateness of generic prescribing by for example compiling a list of generic switches and agreeing these with practices.

The COMPASS system provides on a quarterly and annual basis a range of prescribing reports and therapeutic notes to all GPs, Local Health and Social Care Groups, Boards' prescribing advisers and the Department. Each report provides an analysis of the prescribing at individual practice level, suggesting alternative approaches that might improve effectiveness, safety and patient care and showing

[54] However it may be that for example the quicker uptake of new drugs in Northern Ireland, whilst increasing the drugs bill, will lead to lower healthcare costs overall as other forms of treatment are required to a lesser extent.

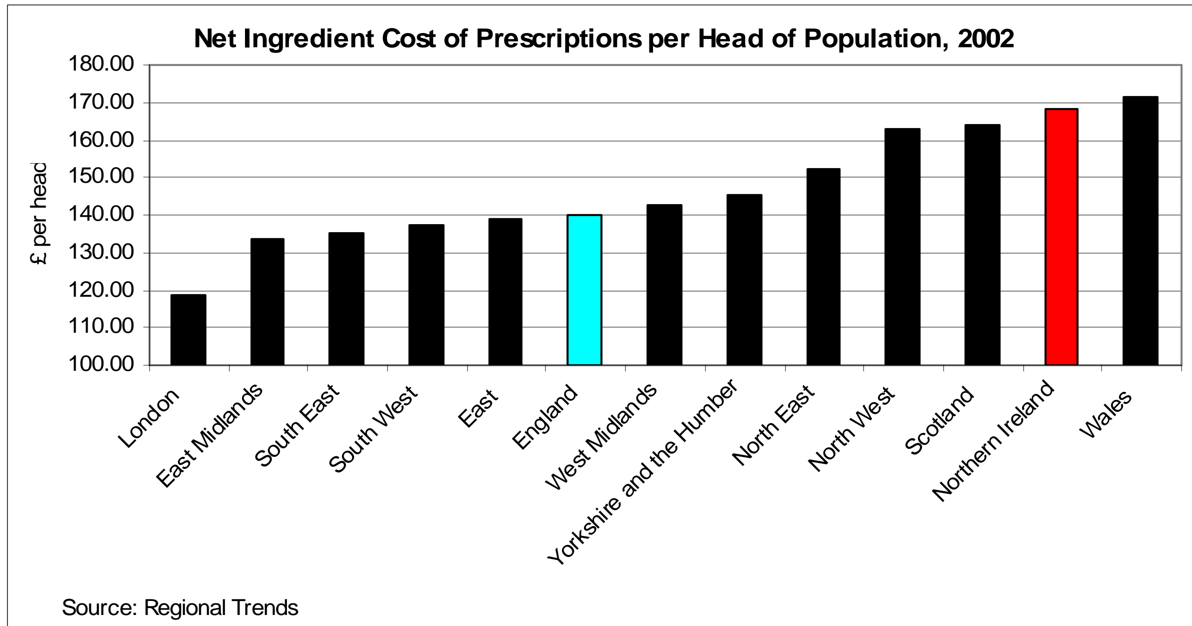
potential financial savings. The report allows practices to see how their prescribing compares to that of other practices in Northern Ireland and how they have changed compared to the previous year. The impact of using generic rather than proprietary drugs is emphasised.

All Boards have prescribing policies – these recognise any relevant regional strategic direction (e.g. a target in Priorities for Action) as well as Boards' own prescribing priorities. Once again, the Board prescribing advisers will take the lead in working closely with practices on these policies and may develop prescribing formularies for the practice to use as a tool to provide direction to practice prescribing where, for example, a problem has been identified with a certain type of medication

Overall, therefore, the interaction with GPs on prescribing is directed towards the provision of information and the application of persuasion and incentives as means of changing behaviour. There is currently no use of sanctions to influence prescribing practice. During the consultation process there were concerns expressed regarding this approach as GP's could make short-term improvements in order to obtain rewards and then return to past behaviour patterns before improving performance to receive further rewards in an ongoing cycle.

In 2003/04, £314m was spent on 26.6m prescriptions in Northern Ireland, 97% of which was paid for by the exchequer. Figure 3.18 below shows that Northern Ireland has the second highest spend per head on prescriptions of the UK regions

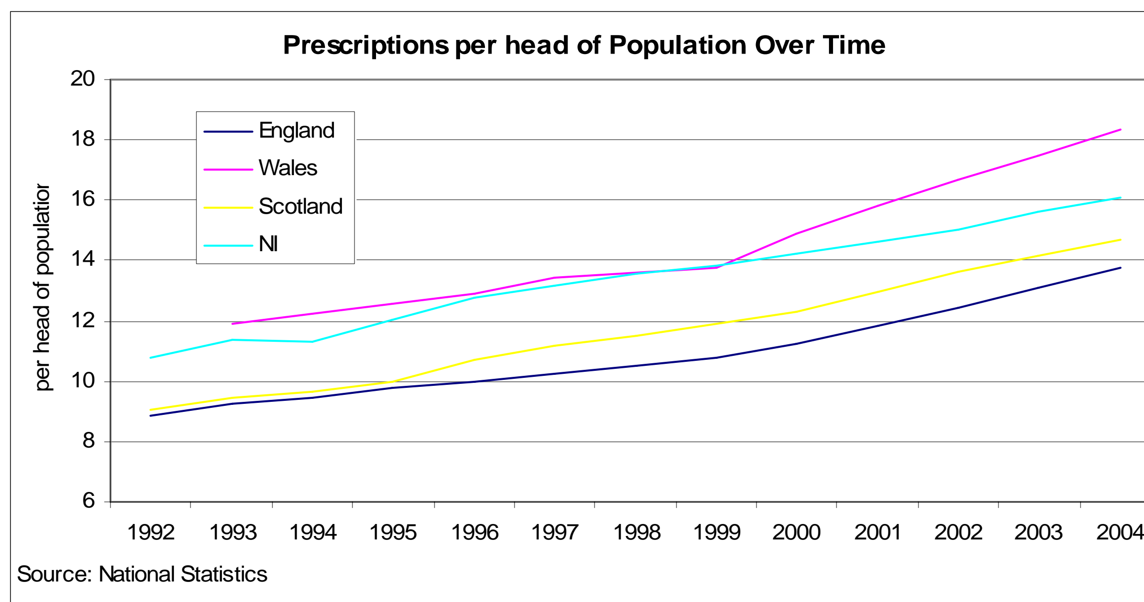
Figure 3.18: Net Ingredient Cost per Head of Population in Northern Ireland is the second highest of the UK regions.



In 2003, spend per head on prescriptions was 29% higher in Northern Ireland than England due to higher numbers of prescriptions being dispensed (+18%) and higher net ingredient cost per prescription item (+8%). It should be noted however that prescriptions in Northern Ireland tend to be in the less expensive forms of treatment,

so that the differential in unit costs is significantly higher than that suggested by the headline figure.[55]

Figure 3.19: The number of prescriptions dispensed per head of population has increased by 43% over the past ten years in Northern Ireland compared to 46% in England.



In addition, the number of prescriptions dispensed has increased by 48% over the past decade, so that the overall cost has increased by 131%. However, as figure 3.19 shows, Northern Ireland has had the slowest growth in prescriptions per head of the UK countries.

One of the main reasons for the higher unit cost of prescriptions in Northern Ireland relative to England is the greater use of proprietary drugs, which are on average over five times more expensive than generic drugs. In 2003, 41% of prescriptions dispensed[56] in Northern Ireland were for generic drugs compared to 55% in England. If Northern Ireland were to achieve the same generic dispensing rate as in England, this would reduce prescription costs by 18% equivalent to £55m. In terms of the number of prescriptions per head, over two-thirds of the differential with England is due to just five classes of drugs [57]

As part of the £474 DHSSPS Efficiency Programme [58] £83m is due to be saved over the period 2005/06-2007/08 by abating the growth in pharmaceutical costs through a

[55] Based on analysis of 2002/03 figures for NI and England Cost Weighted Activity Index which showed unadjusted unit costs to be 18% higher in Northern Ireland and 29% higher once adjusted for differences in prescribing distributions between different types of drugs.
[56] DHSSPS state that there is no data available on generic *prescribing*
[57] Based on 2002/03 data 68% of the differential in prescriptions per head can be accounted for by Analgesics, Antibacterial Drugs, Hypnotics And Anxiolytics, Antidepressant Drugs and Ulcer-Healing Drugs which collectively account for 35% of prescriptions in Northern Ireland.
[58] The Chancellor's Budget speech in Spring 2003 announced a cross–cutting review of efficiency in the public sector to identify the scope for efficiencies in public spending. In his 2004 Budget, the Chancellor announced that the Government would set targets to achieve cumulative efficiency gains of 2.5% per year over the SR2004 planning period. The Secretary of State has decided that parallel reform and efficiency programmes should apply to the public sector in Northern Ireland. To ensure delivery of this substantial efficiency programme is achieved, departments have produced Efficiency Technical Notes (ETNs) providing specific and quantified information on the actions departments will take over the next three years to deliver their efficiencies.

number of initiatives. These include therapeutic tendering[59], repeat dispensing projects as well as the roll-out of Integrated Medicines Management[60] across the HPSS which to date, inter alia, has had a significant impact in reducing length of stay and readmission rates.

Conclusion

The overall impression from the consultation process was a lack of integration between GPs and the rest of the primary care sector. There was also significant frustration on behalf of GPs, related to the fundholding issue, that the Department and Boards did not appreciate their work, communicate sufficiently, or consider the views of GPs when setting policy. On the other hand, GPs were viewed as too often operating independently of other parts of the system (for example, in not appreciating the treatments that could be provided by Allied Health Professionals). Whilst the Department would clearly wish for GPs to have greater involvement with LHSCGs and multi-disciplinary working in general, there is clearly a problem with the general relationship GPs currently have with the DHSSPS and Boards..

It is important that there is clear understanding and common purpose between GPs and the rest of the health & social care sector. GPs not only provide an important service to the public, but, in their role as gatekeepers, influence the commitment of a significant amount of health care expenditure. Given the high levels expenditure on prescription drugs and attendances at A&E, it is crucial that this interface operates effectively. At the same time it is not clear that one of the main opportunities to stimulate reform (the revised GMS contract) has been taken - for example, in terms of the role that GPs have in managing the flow of patients into hospitals. The initial impression is that there has been significant cost with little benefit in terms of patient outcomes or GP morale[61].

> **Recommendation 17: An assessment should be carried out on the implementation of the GMS contract in Northern Ireland to examine whether the actual improvements in quality outweigh the cost. In light of the finding, the GMS contract should be revised as far as practicable**

Despite implementing various initiatives to reduce the problem, Northern Ireland still has a significantly higher level of spend on prescription drugs per head of population than the rest of the UK. As with the rest of the health & social care sector this can be linked in part to the absence of sanctions to dissuade poor performance.

> **Recommendation 18: New mechanisms involving greater use of sanctions are needed to tackle high prescribing costs and to encourage greater use of generic drugs.**

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[59] Treatment is prescribed from a clinical specification for medicine rather than the availability of individual proprietary drugs.

[60] Integrated Medicines Management involves re-engineering the system for medicines management covering the patient care journey by applying a dedicated clinical pharmacy programme complimenting medical and nursing input and developing a scheme for product standardisation across the primary and secondary care sectors.

[61] Although payment for QOF achievement points may improve morale the January 2005 survey of GPs indicated that 48% would be willing to receive less pay for a smaller workload whilst only 21% were happy with the revised GMS contract.