

HEALTHCARE – A NEW DIRECTION

TOWARDS PRIMARY CARE

Transforming our health service into a fair, efficient and responsive service is a major objective for the Labour Party.

The daily litany of overcrowded accident and emergency departments, dirty hospital wards, overworked staff, waiting lists for patients, inequity in treatment, queues for orthodontic treatment; deficiencies in community services and shortages of specialists in different regions of the country is not acceptable.

We are determined to bring about real change.

Real improvements will be our priority in a new government. Labour in government will be dedicated to meeting the needs of our sick and elderly.

There are no quick-fix solutions in health. A sustained strategic approach can deliver good quality care at an appropriate level of access but it must be adequately resourced and properly planned. The growth in our population to 4 million puts additional strains on services. This growth in population must be factored into any forward planning, as does the ageing of our population.

A shift towards primary care will serve to ensure ease of access close to the patient's home. It will build on the strengths of community care and encourage greater independence for patients. It must not be used as a way of making cutbacks or reducing standards. Primary care can only be quality care if it is properly resourced and funded.

A new direction towards primary care will deliver accessible care in the community and better value for money.

Labour is conscious of the health professionals and staff who work in often-stressful conditions to meet the needs of patients. We are also conscious that they—and their patients—deserve clear political leadership to bring about the improvements that are so desperately needed.

The absence of clear and committed leadership in the area of health is a hallmark of the current government. It is clear that strong political leadership from a new Taoiseach and Tánaiste down is required if this challenge is to be met.

In a new government Labour will ensure the redirection towards primary care as outlined in this document.

The current government gave lip service to the development of primary care but killed off its own Primary Care Strategy by starving it of funding.

Most importantly the government has failed to develop a health policy that can make a significant difference to the delivery of patient care.

Liz McManus TD,
Deputy Leader
Spokesperson on Health
April 2006

WHAT IS PRIMARY CARE?

Primary Care, as described by the World Health Organisation, is first contact, front-line, ongoing, comprehensive and co-ordinated care. For many people the local family doctor is the face of primary care.

In accordance with the WHO, the aspiration for any primary care policy is as follows: “first contact care is accessible at the time of need; ongoing care focuses on the long-term health of a person not on the short term duration of the disease; comprehensive care is a range of services appropriate to the common problems in the population available at the primary care level, and; co-ordination is a role by which primary care acts to co-ordinate other specialist services that the patient may need.”¹

WHY PRIMARY CARE?

A shift of emphasis to Primary Care will be more efficient, more desirable, closer to home and integral to communities.

The importance of increasing access to primary care was highlighted recently by reports that thousands of patients are bypassing GPs and going directly to hospitals for medical help, adding to the problems in A&E departments.

In some cases over half of patients, 54%, who presented at a hospital had not gone to a GP first. ²

The Government’s own strategy on primary care – which appears to have been jettisoned – “Primary Care, A New Direction” made grand statements on integrating primary and secondary care.

However if the present Government had upheld its promised strategy for improved primary care many of the key crisis points facing A&E would have been addressed.

GENERAL PRACTICE

General Practice is not the totality of primary care but along with the community nursing service it is, and will remain, the **core of community-based health care**. The tradition of a personal or family doctor who treats over 90% of all ailments, without recourse to hospital care, who presents to the health services and who advises and coordinates referrals to secondary hospital and specialist care is something that should be supported and cherished in light of present day needs.

There is need for reform of a system, initiated by the Health Acts of the early 1970s, and designed to meet the health care needs of people of a society with different needs and significantly different resources. Those Health Acts in the early 1970s introduced significant reform over the then dispensary/private scheme in place at the time. That reform had the effect of abolishing the distinction between private patients and medical card patients in Irish general practice. Under the present GMS contract the GP is obliged to treat medical card patients and private patients on a basis of total equality. This must remain the case under the new contract in the new conditions.

General Practitioners today are better trained and have greater access to investigations, treatments and preventative interventions than they had 35 years ago. Many of these activities lie outside the present GMS contract. For example, under the present contract, GPs are not required to provide a cervical screening service for their GMS patients (although some do). Nor are they resourced to provide the growing number of preventative interventions, which are part and parcel of contemporary general practice.

Reform is necessary to allow a growing number of preventative interventions to take place in the community and to allow for high quality management of people with chronic illnesses - in partnership with the hospital services. The core of an acute illness service - where people and families have direct same day access to a personal doctor - must be protected.

Labour Recommends:

- Greater access to GP care by raising the numbers of people accessing primary care
- Resources to be provided to ensure high-quality management of chronic illness in General Practice on the basis of equality for all patients in partnership with specialist hospital services. An agreed core of chronic conditions will be identified which will attract universal state eligibility for health care. For example, diabetes mellitus, chronic ischemic heart disease, chronic lung and neurological conditions such as COPD and Multiple Sclerosis
- An agreed protocol for a Primary Care Preventative Strategy that will be free at the point of delivery. This will include universal cervical screening; secondary cardiac preventative program; a robust *well man* and *well women* service; screening for sexually transmitted infections, and other services that meet the criteria to ensure health improvements and cost benefits to the community

MEDICAL CARDS

The percentage of the population who have medical cards and therefore direct free access to the general practitioner has declined from **37.5% in 1988** to **28% today**.³

The cost of attending the local family doctor, which averages at about €50 a visit, is simply out of reach for many people.

Therefore although GP's fees have increased by 87% since 1997, the percentage of the population entitled to a full medical card has fallen to the lowest level in 30 years.

Thus the absence of a medical card causes anxiety and stress for many and results in people neglecting their own health problems. Parents, in particular, often neglect their own healthcare to ensure that that their children get any necessary medical care.

Organisations such as Society of Saint Vincent de Paul are often asked to help poorer households pay medical costs.

In a survey carried out for the Irish College of General Practitioners published in November 84% of the respondents felt that the main obstacle to accessing GPs was a lack of medical card.⁴

It was revealed in the same study that GPs feel that there is a real barrier for those just above the medical card threshold to access their services and called for increases in the numbers eligible for the medical card.

The 2001 introduction of the “over 70s” medical cards, regardless of income, had the effect of providing medical card cover to people who could afford services while thousands more on very low incomes are denied such cover. The result was the introduction of a new inequality into the system.

In addition, **the capitation payment rates to GPs for people “over 70s” who receive medical card on a non-means tested basis are four times higher** than the capitation rates for lower-income “over 70s”. This results in a greater incentive for GPs to set up in wealthier areas, drawing them away from poorer areas where they are needed. This in turn places extra pressure on accident and emergency departments that then must attempt to fill the gap.

Date	% Population covered by medical cards
June 1997	34.37%
June 2002	30.81%
September 2004	29.39%
February 2006	28.32%*

* When the numbers of non-means tested medical card holders for those aged 70 and over are discounted the numbers of those entitled to medical cards would fall by c. 113,000 or **2.7%**⁵. (This reduces the actual figure covered by medical cards today to 25.6%.)

The recent introduction of the GP only cards has done little to change the numbers of those eligible for medical cards, despite Government rhetoric. In fact, one year from the announcement of 200,000 GP visit medical cards, only around 4% have actually been issued.⁶

The current medical card scheme does is far too limited and does not cover all those in need of a medical card. This results in significant numbers of patients who cannot access primary care when they need it. Therefore, the income thresholds need to be raised.

Current guidelines for Medical cards:⁷

Weekly Income Limit (Gross less tax and PRSI)

Category	Aged under 66	Aged 66-69
Single person living alone	184 euro	201.50 euro
Single person living with family	164 euro	173.50 euro
Married couple/Lone parent with dependent children	266.50 euro	298 euro
Allowance for first 2 children aged under 16	38 euro	38 euro
Allowance for 3 rd and subsequent children under 16	41 euro	41 euro
Allowance for first 2 children aged over 16 (with no income)	39 euro	39 euro
Allowance for 3 rd and subsequent children over 16 (no income)	42.50 euro	42.50 euro
Dependants over 16 years in full-time non-grant aided third level	78 euro	65 euro

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Labour Recommends:

There is a strong argument for free GP care for all, which we support.

- As a first step, it will be a priority of the Labour Party to raise the number of medical card patients to approximately **40% of the population***

*With the population currently at 4,130,700⁹ 40% of the population is 1,652,280. According to the Department of Health, as of February 2006, approximately 28% of the population are eligible for the medical card. This

amounts to 1,159,794 persons. The difference between the two figures is approximately 492,486 persons.

SOCIAL EQUITY FOR OUR HEALTH SERVICE

The Labour Party believes that a Fair Society leads to a healthier society. At present, those from a poorer background experience poorer levels of health than those from wealthier backgrounds. People from poorer background have difficulties accessing health services. People from poorer backgrounds tend to suffer greater ill health and die at a younger age.

Poverty, income inequality, social exclusion and poor health are inextricably linked. Between 1989 and 1998 the death rates for all causes of death in the lowest occupational class were more than three times those of the highest occupational class. Compared to those with high income, people on a low income are 52% less likely to have good health.¹⁰

The link between homelessness and mental illness is well documented; with up to one third of those living on the streets experiencing severe mental illness, which forces many into further social exclusion.¹¹

As it stands, the health service is based on the principle that, “Those who need most care get least and those that need least care get most”.

This must change.

Labour in government will provide

- A concentrated effort to deal with social and economic disadvantage
- Special incentives for doctors working in deprived communities, in recognition of the higher workload involved per patient
- Encouragement and incentives for doctors providing services in remote rural areas
- Priority investment in capital infrastructure in rural and urban areas of deprivation

MANPOWER

For more than 25 years, the Irish and EU student entry to medicine has been capped at 305 places per year. The Fottrell Report¹² recommendations calls for the number of places for Irish and other EU medical students in the State to be more than doubled (bringing the numbers up to at least 725). The Labour Party supports this view.

We are not educating enough doctors or training enough general practitioners. This must be addressed urgently.

In light of the fact that it takes around 11 years to train a GP, the rate of reform of medical training needs to increase from the government suggested figure of 70 new places for September 2006.

The feminisation of the GP services will also lead to a need for GPs. 62% of GPs at the present time are male, however, 70% of GPs in training are female. If female GPs tend to work fewer hours this will have implications for the numbers of GPs required in the future.¹³

Also according to the Irish College of General Practitioners (ICGP) one third of the country's 2,400 GPs will retire in the next 10 to 15 years. Yet, a recent survey of GPs indicates a willingness to work on past 65 years of age. This offers additional capacity while keeping valuable experience within the system.

Labour Recommends:

- The number of GP training places should be expanded to approximately 160 annually
- The numbers of medical undergraduate places for Irish and EU citizens must be increased to take into account the growing needs of the population
- The continuing medical education and training of the existing general practitioners must be resourced to provide the capacity for the above reforms
- The role and training of practice nurses should be expanded
- Professional courses in the management and administration of primary care should be resourced in 3rd level institutions
- GPs over 65 years should be facilitated in continuing to work

INTEGRATION OF PRIMARY HEALTH CARE SERVICES

A primary health care strategy should be implemented and resourced in the light of emerging needs to encourage the integration of all community based health care services.

Labour Recommends:

- The integration of all health services provided at a community level including mental health services; paediatric services; dietary services; physiotherapy; podiatry; ophthalmic services; public health services; palliative care services; and nursing home care. Agreement should be negotiated for this to happen
- Incentives for the creation of group general practices where a comprehensive range of services can be provided more easily and there should be support and encouragement for groups of existing single handed general practitioners to provide a similar range of services
- The integration the community based district nursing service with general practice
- Every district should have an identifiable Primary Care Centre with emergency access via good paramedic/ambulance service
- The designation of Primary Care Centres to be incorporated into the Development Plan process of Local Authorities

INTEGRATION OF PRIMARY AND SECONDARY CARE

Because of technological advances, the greater integration and the rapid exchange of information between primary and secondary care has become possible. At the moment the disconnect between GP and hospital services can lead to unnecessary waiting times for patients and inefficiencies in the use of staff and resources.

Labour Recommends:

- There should be greater direct access for patients from general practice to hospital-based investigations without referral to an outpatient clinic. As much investigation as appropriate for the patient should be carried out before referral to hospital or specialist
- Information systems in primary and secondary care should be integrated to allow for the easy transfer of information in the interest of the patient
- Schemes to encourage specialist integration in primary care should be encouraged starting with psychiatry, paediatrics, medicine of old age
- Irish College of General Practice/Irish Medical Organisation nominated members should be appointed to the Board of Management of every acute hospital in the country

OUT OF HOURS CARE

The difficulty in accessing a GP outside of normal surgery hours is an issue in some parts of the country.

This is a vital service that if delivered effectively nationally can ease pressures on our accident and emergency services.

Labour Recommends:

- Group practices should be encouraged to provide new opening hours to take into account the new working practices of their patients
- GPs and the HSE must ensure that their patients are covered for out of hours emergencies by fully qualified GPs. This can be done in a number of different ways depending on local circumstances e.g. co-ops, group rotas or commercial deputising services with particular encouragement of co-ops
- Service standards should be agreed. In particular, the time between the placing of the emergency call and the arrival of the GP

INFORMATION AND DATA COLLECTION

In order to plan the services into the future it will be important to modernise and integrate information and data collection.

Labour will ensure:

- Universal patient registration whether private or public
- Robust data collection systems in general practice
- GP based audit and research

STANDARDS AND ACCOUNTABILITY

The necessity for standards and a transparent system of accountability has become increasingly apparent for some time.

Labour Recommends:

- Urgent need for legislative change to allow for compulsory peer review by the Medical Council of standards of care
- Resources, protected time for continuing medical education and encouragement of general practitioners to keep up to date and maintain standards
- Making the Minister for Health answerable for parliamentary questions ensuring proper accountability in relation to the HSE

CARE FOR THE ELDERLY

By 2026, the proportion of people in the population over 65 will have doubled.¹⁴ At present many elderly people are admitted through A&E and have medical conditions that are not suitable for day cases. Appropriate care for the elderly is essential.

It is a fact that the vast majority of older people, 89%, want to live at home with outside support rather than live in institutional care.¹⁵ This aspiration must be supported.¹⁶

A recent cross border study showed that Northern Irish old age pensioners are more likely to be getting home help, chiropody and primary care than those in the Republic.

The same study also showed that just 7% of OAPs have home helps compared with 17% in Northern Ireland.

About 5,000 of the 23,000 residents of long-term nursing homes or in public hospitals could live at home if adequate supports were provided. Yet there have been punitive reductions in the numbers of service hours of home helps in recent years.

From 2002 to 2004 there was a reduction in the number of home help hours of 730,000 hours. In some areas of the country, the cuts of home help hours amounted to a cut of 40% of hours available.¹⁷

Labour Recommends:

- The expansion of community support services for elderly people to live independent lives as far as is practicable
- An end to the “zero hour” contract for home helps—this results in pay being reduced to “nil” where a client is hospitalised or even dies
- An increase in the number of home help hours
- While there is a good network of home care teams already established around the country, there is an inequity in that some are funded on a voluntary basis and others receive state funding

COMMUNITY CARE BEDS

The Minister for Health and the CEO of the HSE have maintained that the need is not to provide more acute hospital beds but to develop nursing beds in the community. While they have been trenchant in their view, the reality is that the Government has presided over a reduction in the number of community nursing beds.

Since 1997, there has been a worrying decline in the number of public community nursing beds in many areas across the country.

For example at least nine areas have fewer community beds now compared to when Labour was last in power, including:

Area	Community beds in 1997	Community beds today
Dublin South City	290	210
Limerick	432	372
North Tipperary	199	156
Meath	226	201
Westmeath	258	230
Longford	184	168

This decline is a stark contradiction to the government rhetoric on the issue and highlights an important need that must be addressed.

It should also be noted that this information was obtained by way of parliamentary question that was submitted on 29th November 2005. The response was given four months later on 29th March 2006 and was incomplete. We are still awaiting the full data.

The lack of these beds has resulted in many people, particularly older people, spending longer in acute hospital than appropriate.

The present Government has failed to deliver on its promise of community nursing units as stated in the 2001 Health Strategy.

The Labour Party will ensure that, where appropriate, older people can be cared for closer to home according to their wishes.

Labour Recommends:

- The need for at least 1,500 additional community beds by 2010¹⁸ to meet current and future needs
- In view of this need, we recommend a planned development programme across the country

PALLIATIVE CARE

At present we welcome the development of hospices in Ireland, but we are concerned at the fact that there is no uniform funding across the country to support these hospices.

Labour Recommends:

- A target of having a hospice in every former health board area
- A sufficient level of state funding uniform across the country
- A palliative care team in the local hospital/Primary Care Centre
- Best Practice Protocol in place in hospitals to ensure dignity at time of death

MENTAL HEALTH SERVICES

In the majority of cases of a person experiencing mental health difficulties the GP is the first formal contact they have with the health service. The GP becomes the “gatekeeper” and often is the sole means for referring those in need on to mental health services. As in most illnesses, early intervention is key for mental health.

Labour recommends:

- Everyone should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services
- We are calling for the development of primary care teams including social workers and mental health professionals – so that a person may be treated within a primary care team or within a community care network where possible
- The needs of our young people with regard to mental health must be addressed. Community based services must be established for early intervention and treatment for younger people
- In addition, the numbers of suicides needs to be addressed and to this end we would like to see Suicide Prevention Programmes established around the country

ROLE OF THE PHARMACIST

We recognise the role of the pharmacy as a key provider within primary care.

However, at present there is no regulation of the Pharmacy Sector, making it impossible to be struck off the register to practice, even in extreme cases. We are calling for the implementation of such legislation.

Labour Recommends:

1. There is an urgent need to bring in legislation to deal with the lack of proper regulation within the Pharmacy Sector
2. We want to ensure there is no conflict of interest between the pharmacies and General Practice
3. An equitable geographical spread of pharmacies around the country

DENTAL SERVICES:

Labour will commission a comprehensive review into public funded dental services to critically examine value for money, coverage, accessibility and equity.

In particular we will examine the possibility of one, unified state funded scheme, with one standard of care, so that patients can easily understand their eligibility. We would make it a clear priority to ensure that those with physical or mental disease or disability are not denied appropriate and comprehensive dental services.

COMMUNITY PARTICIPATION

Within Primary Care there is great potential for the encouragement of good health through community participation and personal responsibility.

Labour Recommends:

- Establishment of a Minister of State for Public Health
- The development of programmes that encourages exercise, health eating, giving up smoking etc.
- There should be an audit of every community in Ireland with regard to their capacity for good health in the community. That means that people should have access to a swimming pool and accessible sports grounds
- Every school should have a school hall to combat the growing problem of obesity amongst our youth
- Recognition to be given to providing crèche and preschool facilities with breakfast facilities in targeted areas
- Encouragement of research into new technologies to assist patients to manage their own conditions where possible

CONCLUSION:

The Labour Party believes in the need for a new direction towards primary care.

There has been a growing acceptance that to improve the equity, effectiveness, efficiency and the responsiveness of our health services the role of primary care must be paramount.

This primary care system must be accessible on the basis of need, and not means.

However, as the Labour Party seeks to drive this agenda, it is only on the basis that the quality of care one would receive would be as good as that one would receive in a hospital.

There will be no cut backs on the quality of care.

It is vital that primary care is well funded to take its central, front line role in our health service.

A new direction of emphasis to primary care will mean a more efficient, more responsive service that is closer to home and more integral to communities. We recognise that it is not the solution to all the problems in the health service and that patients will often need to avail of secondary care in the acute hospital system.

However, a well-resourced and well-developed primary care system can make a major difference to ensuring that people have access to health care when they need it and to the highest standard.

Sources:

- ¹ WHO, 2004, www.euro.who.int
- ² Tribal Secta consultants reports, as reported in Irish Times, 21 April 2006
- ³ Figures on medical cards obtained by way of Parliamentary Questions
- ⁴ Survey carried out with 718 responses out of 2,419 members of ICGP and published in "Health Inequalities and Irish General Practice in areas of deprivation", November 2005
- ⁵ Information by way of Parliamentary Question and the Health Report by Maeve-Ann Wren and Dale Tussing, November 2005
- ⁶ Information by way of Parliamentary Question
- ⁷ Department of Health website
- ⁸ These income guidelines for medical cards can also be subject to allowances for childcare, travel costs, rent and mortgage
- ⁹ CSO, September 2005
- ¹⁰ "Health in Ireland, An Unequal State", by Public Health Alliance Ireland, 2004 and www.publichealthalliance.org
- ¹¹ Ibid.
- ¹² Two reports calling for major reform of medical education and training from undergraduate level through to postgraduate specialist training were published in 2006. The Report of the Postgraduate Medical Education and Training Group chaired by Dr. Jane Buttimer Report of the Working Group on Undergraduate Medical Education and Training, chaired by Prof Pat Fottrell
- ¹³ Healthcare Skills Monitoring Report, FAS, 2005
- ¹⁴ "An Age Friendly Society - A Position Statement" by the National Council on Ageing and Older People, 2005
- ¹⁵ Research published by National Council of Ageing and Older People, November 2005
- ¹⁶ Study entitled "One Island-Two Systems", Institute of Public Health in Ireland, 2005
- ¹⁷ Information from Parliamentary Question
- ¹⁸ Aidan Browne, HSE, at the Joint Committee Health and Children, 30 March 2006