Submission new GP Contract for all children aged under six

February 2014

The Irish Heart Foundation (IHF) is the national charity supporting people with heart, stroke and blood vessel disease. The Foundation promotes policy changes that reduce premature death and disability from cardiovascular disease and advocates for better patient treatment and services.

The IHF strongly supports the Government’s health service reform programme and believes that free GP care will have a significant long-term impact on the nation’s health by delivering more effective healthcare in the community at the lowest level of complexity and cost. We therefore welcome the publication of the new GP Contract to facilitate the introduction of free GP care for all children aged under-six. In particular, the IHF supports the intention to ‘reorient the focus of primary care toward active health promotion, disease surveillance, prevention and appropriate management of chronic conditions’ (Consultation document).

The primary purpose of our submission relates to how the GP contract for under-sixes can promote positive cardiovascular health among children. We also raise some issues we believe should be addressed prior to implementation. In commenting on the contract, the IHF is cognisant of the needs of older people living with cardiovascular diseases, many of whom have multiple care needs, who also require good access to primary care services.

Summary

GP contract for under-sixes

- Clarification is required as to whether this contract for under-sixes will form the basis of the contract that will be rolled out for all other ages.
- The health promotion elements of the contract should be more clearly defined. In particular, the IHF would welcome consultation on the ‘Healthy Ireland Assessments’.
- Further clarity is required in relation to children’s entitlement under the contract to services provided by primary care team members beyond the GP.
- Clarification is required about what the new contract means for families with young children currently covered by medical cards, or GP visit cards. Families with medical cards should not lose entitlements as a result of coming under the new contract.
- The contract should aim to address health inequalities and recognise the higher health needs of some patients.
- An easy guide for parents should be developed to outline exactly what care their child will be entitled to under the contract.
- Appropriate funding must be provided to resource the primary care system.
- No charges at the point of access should be introduced in this, or any of the subsequent GP contracts.
- The IHF suggests that a mid-term review of the contract be undertaken.

Future roll-out of free GP care for people with cardiovascular disease and other chronic conditions

- In progressing the roll out of free GP care for all, particular attention should be paid to people living with chronic conditions and ensuring they have access to primary care services.
- The expansion of free care to under-sixes should not have any negative impact on access to primary care for people living with chronic conditions, or who require medical cards as result of low income.
The draft GP contract for children under-six

The IHF supports a system of universal access to primary care, which will ensure the best use of healthcare to improve the health of the population. The IHF is primarily concerned about how the GP contract for under-sixes (and subsequent contracts for the wider population) will operate from a patient perspective and that the benefit to patients is maximised. Free access to GP care could help ensure children are healthy and active, thereby contributing to overall public health and to reducing the burden of cardiovascular disease. In particular, the IHF recognises the great potential for GPs to assist in weight management programmes with children.

Good health is crucial for children and young people because it enables them to make the best of their opportunities as they grow. Fairer Society, Healthy Lives (the Marmot Review of the social determinants of health in the UK)¹ recommended that in order to reduce health and social inequalities, every child needs to be given the best start in life. Current trends in relation to diet, physical activity, obesity and smoking and the levels of health inequalities experienced by Irish children illustrate the need to make children’s health a national priority.

More Irish children are overweight than in most European countries.² Irish children are drinking from a younger age and drinking more than ever before³, and take up smoking at a lower age than any other EU country⁴.

The key factors for developing CVD (raised cholesterol, high blood pressure, overweight and obesity and smoking) all develop over a person’s life course, with many taking hold during childhood, even as early as foetal development.⁵ A focus on promoting and protecting children’s cardiovascular health has the potential to produce long and short term benefits – protecting children from heart-damaging risk factors and encouraging the development of positive health behaviours for life. The WHO has concluded that the well-known lifestyle factors, (unhealthy diet, low levels of physical activity and smoking) and biomedical risk factors (obesity, high blood pressure, high cholesterol) in children – exactly as in adults – are associated with the accelerated development of atherosclerosis and a higher risk of cardiovascular disease.⁶ Habits are established during childhood, and measures taken to influence the lifestyle of children at an early age, including through primary care, are more effective than subsequent attempts to change habits already established. The NICE (2010) CVD prevention guidelines⁷ for the UK note the importance of taking action to prevent the elevation of CVD risk factors among children, by ensuring they have a healthy, balanced diet and are physically active. This supports the principle of ‘primordial prevention’, ensuring the low cholesterol and blood pressure levels seen in normal childhood are maintained throughout life. This can prevent risk factor ‘tracking’ whereby children with obesity, elevated blood pressure or raised cholesterol are very likely to become adults with above-average risk-factor levels.

The National Cardiovascular Health policy 2010-19⁸ makes direct reference to the importance of children’s health and to the vision of the European Heart Health Charter. The policy sets specific targets for children in

---

⁴ European Commission (May 2012) Special Eurobarometer, Attitudes of Europeans to Tobacco.
⁵ National Heart Forum (2010) ‘Submission from the NHF to the Independent review on poverty and life chances’.
⁸ On the verge of a period of centennial reflection on the origin and direction of the State, it is also noteworthy that in the next few years, and for the first time in the history of the Irish Republic, the number of children in Ireland will approach one
relation to healthy weight, physical activity, smoking and salt consumption and population-based surveys to track the health profiles of adults and children. However, specific actions to achieve these targets are not included in the policy.

There is widespread concern about the increasing prevalence of diet-related ill health, including overweight and obesity among children. There is a significant likelihood that some of these overweight and obese children will have multiple risk factors for cardiovascular diseases, type 2 diabetes and other co-morbidities before or during early adulthood. Evidence suggests that an overweight adolescent has a 70% chance of becoming an overweight or obese adult.

The draft contract for children under six

Health promotion activities

The Government has made significant commitments to improving population health in Healthy Ireland (2013) which will need to be supported by health promotion activities in primary care. The draft contract references health promotion activities but provides limited detail on what they will entail. The contract does not refer to any additional training to be provided to GPs and the primary care team to facilitate the reorientation to health promotion within their services. The IHF believes the health promotion elements of the contract should be more clearly defined.

The contract mandates GPs to undertake ‘Healthy Ireland Assessments’ with all children under six. The IHF would be keen to engage with the Department and the HSE in the development of these assessments and on the health promotion elements of the contract. The IHF would welcome further consultation on both these issues.

Services covered by the contract

The draft contract lists the services covered as: treatment of acute and all conditions; health surveillance; health promotion; provision of information; routine phlebotomy services; administration of vaccines to high risk patients; palliative care and treatment of minor injuries; maintain register of child patients; participate in primary care team (s); medical assessments for the Child and Family Agency; wellness assessments; and sick certs. The IHF believes that further detail is required about the services which children and their parents can receive. The IHF recommends that an easy, at-a-glance guide be developed for parents clearly outlining what the contract covers for their child.

The draft contract states that ‘the importance of local primary care teams is acknowledged, and the Service Provider undertakes to actively participate and cooperate with its local primary care team’ (p.5). Further clarity is required as to under-sixes’ entitlement to services provided by primary care team members beyond the GP.

---

It is important that no child has a reduced entitlement as a result of the new contract. Clarification is required about what the new contract means for families with young children currently covered by medical cards, or GP visit cards. In addition, it would be useful to have a diagram showing the differences (if any) between the current GMS contract and the GP contract for under sixes.

**Focus on reducing health inequalities**

Focusing on health is important for all children, but especially for poorer children, who are much more likely to experience poor health.\(^{11}\) Professor Marmot’s 2010 review of health inequalities in England\(^{12}\) clearly illustrates the social gradient in health, with health outcomes poorer the lower a person’s social position. The review concludes that such health inequalities arise as a result of underlying social inequalities, and therefore cannot be tackled without addressing their social causes. The report highlights proportionate universalism – universal actions applied with a scale and intensity proportionate to the scale of disadvantage – as the most effective approach to reduce the steep social gradient in health.

A focus on proportionate universalism is important for Irish children. Health outcomes in Ireland are distinctly unequal – a 2010 study by the Central Statistics Office shows that people in the most deprived areas have the lowest life expectancy.\(^{13}\) Rates of coronary heart disease and diabetes among the Irish population rise gradually as deprivation increases, with those in the most deprived fifth of the population having the highest rates.\(^{14}\) Evidence from the Growing up in Ireland study has shown how health outcomes for children are socially structured, with poor children having a higher likelihood of poor health outcomes. For example, weight status among 9-year olds was related to social class - 33% of nine-year-olds from Semi-skilled/Unskilled Manual groups were obese or overweight compared with 22% from the Professional/Managerial group.\(^{15}\)

The IHF considers that the contract should reflect the higher needs of some patients and some geographic areas. The IHF is unclear as to whether the contract will include a deprivation element to reflect additional treatment required in areas of disadvantage and for children experiencing health inequalities. Under the contract all children will need to be registered with a GP. The IHF would like clarity on how this will be managed in areas with lower density of GP services, which often tend to be areas of disadvantage. The HSE has developed a resource allocation model based on deprivation and need, designed to provide a mechanism for the allocation of posts in primary care. This model should be rigorously applied to ensure that primary care in all areas of the country have the appropriate resources to meet the needs of their patient profile.

---


\(^{13}\) CSO (December 2010) 'Mortality Differentials in Ireland'.


Appropriate resources and staffing levels in primary care

Even in advance of this new contract, there continues to be concern regarding the level of funding for primary care services and in the development of primary care teams with appropriate staffing levels. The reorientation of the health system to primary care will require a refocusing of budgets towards primary care. IHF is concerned that there are areas in the contract which could be interpreted as articulating a desire to reduce costs. For example, the draft contract states that: GPs should ‘use the most efficient and economic forms of treatment or care consistent with the needs of his/her patients, having regard to the resources available to the HSE and to the budgetary imperatives of government’ (p. 14). Appropriate funding must be provided to resource the primary care system.

Patient charges

Patient charges at the point of access discourage necessary and preventative care and are particularly damaging for people on low incomes. Such co-payments can also increase the administration costs of a system. Equity in healthcare provision comes from the separation of payment from the receipt of care (i.e. not paying at the point of access). Co-payments and patient charges are a regressive form of financing and are damaging to health because they discourage necessary healthcare use by patients. Co-payments put the focus for over-use of healthcare on the patient, rather than on the medical professionals, who should be in a position to properly apportion care according to medical need. The worldwide trend away from co-payment systems (including abolishing of prescription charges in Northern Ireland in 2010) indicates that they have not proved a successful mechanism for improving patient health and cutting healthcare costs.

The consultation document states that: In line with Government Policy (Future Health) the population of the Republic of Ireland will have access to GP care without fees at the point of use, on a phased basis’. The IHF welcomes the fact that in the media, the Minister for Primary Care has also stated that no charges will apply for under-sixes accessing primary care. However, statements have been made that charges for other groups may be considered. The introduction of what has been termed a ‘nominal charge’ (€5-10 per visit) for other patients, (it is unclear whether this could include current medical card holders), would be an inequitable development. The IHF recommends that no charges at the point of access should be introduced in this, or any of the subsequent GP contracts.

Review of contract for under sixes

The IHF would have preferred a piloted, phased approach to the development of this 5-year contract, particularly as this contract will likely set the tone for the forthcoming contracts to provide GP care to citizens of all age groups. The IHF suggests a mid-term review of the contract should be undertaken. To ensure a focus on patient quality and patient experience, the IHF believes that this review should include a strong and independent element of patient oversight.

The current consultation document is complex and as a result it is unlikely that many citizens will input into this consultation phase. The IHF is disappointed that just three weeks was given for such an important consultation. This had limited our ability to consult widely with our stakeholders and reduced the capacity of individual citizens to state their views. We recommend that information sessions / workshops are organised to engage the public and patient representatives in meaningful consultation on the development of subsequent GP contracts.
The Heartwatch pilot covering 20% of GPs has shown itself to be effective. It achieved significant improvements in reducing levels of the three main risk factors (cholesterol, blood pressure and smoking), although little change was achieved in weight and exercise levels; increased the uptake of evidence-based secondary preventative therapies; and improved the quality of care provided by GPs. 81 deaths were estimated to have been prevented or postponed and 522 life years gained over the first 2 years of the programme. The programme was also very cost-effective, with an incremental cost of €7,987 per life year gained. The CVD policy (2010) highlights that building on Heartwatch, a model ‘addressing all patients who can benefit, including high-risk patients (as specified in the ESC Clinical Practice Guidelines ...), is needed to provide proactive and cost-effective cardiovascular care to maximise life expectancy and quality of life’ and the policy also recommends the development of structured clinical care at primary level, including prevention of CVD. See, Department of Health (2006). Heartwatch Clinical Report – March 2003 to December 2005, second report.
For further information contact:
Cliona Loughnane, Policy and Research Manager
Irish Heart Foundation, 50 Ringsend Road, Dublin 4.
cmccormack@irishheart.ie (01) 6685001

Registered charity number CHY 5507