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Note: Private Expenditure on General Practice

MICHAEL DOOLAN, SEÁN PRIOR

HEALTH VOTE

DEPARTMENT OF PUBLIC EXPENDITURE AND REFORM

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Executive Summary

- This note reviews available evidence relating to annual private expenditure on General Practice healthcare (*household out-of-pocket*, as distinct from *State* expenditure) in Ireland each year.
- The purpose of this work is to provide an understanding of the opportunity cost faced by GPs over the course of the implementation of free-at-point-of-access GP care, or 'Universal GP Care' in Ireland, as set out in the SláinteCare vision.
- The note draws on several completed works which have directly or indirectly addressed the subject, as well as several data sources which provide insight and estimations of the total amount.

Key Findings

- While noting that there is no absolute measure for GP private income, and that variation across available measures exists, we estimate that **GPs currently receive in the region of €200m-€220m per annum** from private patients (those without Medical or GP Visit Cards), who make up around 57.5% of the patient base.
- Based on a survey of relevant studies, we estimate the full rollout of free GP care will have a demand effect in the region of +20-40% additional visits per year among the currently uncovered cohort. This will place additional pressure on the GP system, which is thought in many regions to be near or at capacity.
- A 2019 paper undertaken by the D/PER Health Vote estimated that extending free GP care to the entire population *on the same terms as the currently covered cohort* would cost upward of €630m per annum. This note estimates that extending GP care to the population on an *opportunity cost basis* **would cost around €240m-€308m per annum, allowing for a shift in demand.**
- It should be noted however that the realisation of Universal GP Care would imply a reformulation of the model of General Practice in Ireland. This means that the *actual* costs of Universal GP Care will ultimately be dependent on the model of care which is implemented, as well as the specific terms agreed.

While this note is being published as part of Spending Review 2020, it is not strictly a Spending Review paper, which by definition review past expenditure and more broadly evaluate value for money in State expenditure programmes. This note is intended instead as a complimentary piece of information gathering which, it is hoped, will aid in facilitating negotiation and planning of Universal GP Care in Ireland.

1. Introduction

The implementation of universal GP care in Ireland has formed part of the policy agenda of several Irish Governments in recent years. The publication of reports such as *Primary Care: A New Direction* (Dept. of Health, 2001) and *Future Health: A Strategic Framework for Reform of the Health Service 2012-2015* (Dept. of Health, 2012) outlined strategies aimed at developing primary care into the central locus of healthcare provision in Ireland, and with that improving ease of access by lowering or eliminating patient charges. More recently, the cross-party Committee on the Future of Healthcare was established by the Dáil in June 2016, with the aim of arriving at a consensus on a “long-term policy direction” for healthcare in Ireland. Developing an accessible, “affordable, universal, single-tier healthcare system in which patients are treated promptly on the basis of need rather than ability to pay” was of central focus; a central recommendation stemming from the report was a move to free-at-point-of-access GP care for the entire population. While SláinteCare and other reports have sketched out high-level implementation paths for Universal GP Care, there is still need to look further at the policy challenges, associated costs, and structural and administrative decisions yet to be made, that such a move will imply. This note seeks to contribute to that discussion by looking at the economic opportunity cost faced by GPs in the context of a transformation of primary care. The ‘opportunity cost’ simply refers to the value of the economic activity which does not take place as a result of an economic choice – in this case the loss of private consultation fees following the implementation of Universal GP Care. In this sense the note provides some estimation or expectation for the scale of cost which would need to be funded by an alternative channel following a change, thus building on a paper published by the DPER Health Vote last year which provided a costing framework for the extension of free GP care, on the same reimbursement terms as currently agreed in the General Medical Services scheme for Medical Card and GP Visit Card holders.

Several previous estimations and data sources form the basis of the estimations provided in this note; each of these are subject to their own caveats, and none can properly be considered absolute or definitive measures of private expenditure on general practice. As such, this note is not intended to be the final word on the question of GP private income; rather it is an assessment based on available information aimed at informing the Government’s perspective for future policy developments and resulting expenditure considerations.

This note is set out in sections as follows:

- Section 2 briefly reviews the policy context of GP care in Ireland, and some of the main issues and challenges relating to universal free GP care;
- Section 3 lays out the basis of our estimations for current private expenditure on GP care;
- Section 4 provides the basis of our estimations of the expected demand effect as a result of universal free GP care, or the ‘price elasticity of demand’ for GP care;
- Section 5 concludes.

2. Policy Context

At present, GP care in Ireland is provided through a mix of both private and public access streams. While virtually all GPs in Ireland are independent private contractors (i.e. not directly employed by the State) who provide private consultations at market rates, the majority also participate in the General Medical Services (GMS) scheme, through which the State covers the cost of access of “persons for whom acquiring such services would present undue hardship”. GMS eligibility is based on economic means, considering family size, income, and expenditure on mortgage/rent and childcare. The numbers of people eligible for the GMS and those not eligible are provided below in Table 1.

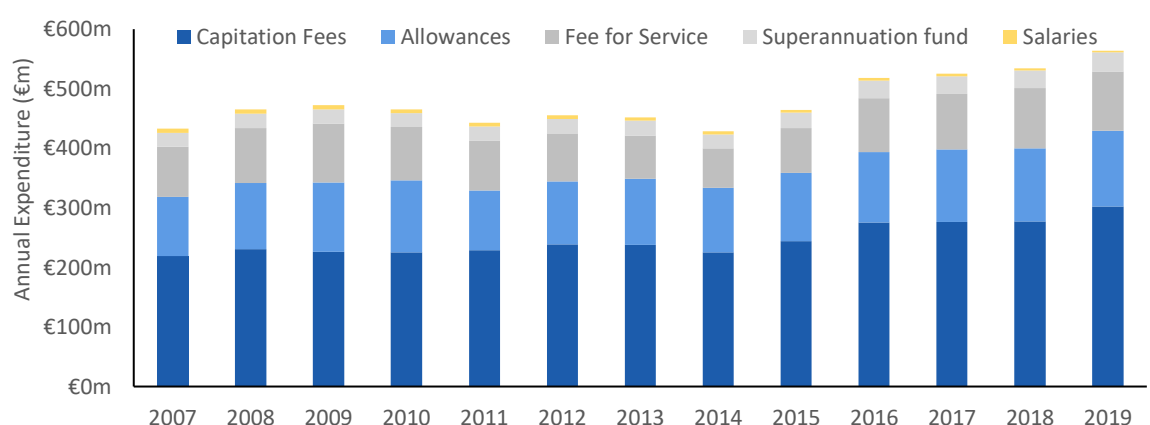
Table 1: Breakdown of Public/Private GP Eligibility (2020)

Category	Number	% Population
Public Patients	2,090,207	42.5%
- of which GPVC holders	528,258	10.75%
- of which MC holders	1,561,949	31.75%
Private patients	2,831,293	57.5%

Source: PCRS

Expenditure on Public Patients

Expenditure on public patients through the PCRS programme has remained relatively static over the last twelve years, rising from €433m in 2007 to €564m in 2019; the bulk of this period however saw a consistent drop-off in the number of GMS participants, as the economy gradually improved following the Great Recession. The cost of care per person therefore increased at a higher rate than total expenditure during this period.

Figure 1: PCRS Payments to GPs for Public Patients (2007-2019)

Source: PCRS

The GMS scheme remunerates GPs for services to GMS patients via a number of payment categories. The primary category is “Capitation Payments”, which are fixed rate monthly payments made to GPs based on patient age and gender, and are not tied to the specific number of visits for a given patient. Secondly the GMS contract reimburses GPs for the provision of specific medical services to public patients, such as Chronic Disease Management, Immunisation and Preventative Care. In addition GPs are provided with allowances to assist with the covering of certain costs. Allowances totalled €127m in 2019, or 22% of PCRS expenditure. Secretarial/Nursing (€92m), Annual Leave (€11m) and Medical Indemnity Insurance (€8m) were the three biggest areas, making up 87% in 2019. It is important to point out that these allowances benefit both patient types. A cornerstone policy of GMS care is that there is “no distinction made between public and private” GP consultations; both public and private patients benefit from the time and care of secretarial and nursing staff, and to that degree GMS expenditure subsidises private GP care.

Policy Rationales for Universal Free GP Care

A variety of policy rationales exist for the provision of free-at-point-of-access primary care; these range from public health, health system planning and efficiency, and social equity considerations. Several studies suggest that the removal of access barriers for early and preventative care are linked

to positive health effects across populations¹ and contribute to reducing unmet healthcare need in the population, which remains an issue in Ireland². Reducing and removing barriers to accessing healthcare, perhaps unsurprisingly, is linked to positive public health outcomes. With regard to health system planning and efficiency, it is argued that reducing barriers to care will result in efficiencies over the longer-term, as people access care earlier at a stage when interventions are cheaper, and in the primary care setting as opposed to the acute setting, which is more complex and more expensive to operate. More broadly, populations which are healthier are cheaper to care for; a core tenet of SláinteCare is to move care from more expensive acute setting into the community setting, helping to lower overall costs. Finally, it is often argued from a social equity perspective that access to primary care constitutes a social right which should be provided for by the State. While the purpose of the GMS scheme is to provide care to people for whom attaining care privately would be unduly burdensome, the State does not presently have an obligation to ensure access to *all* people. Consideration of this point will be of particular relevance as the expansion of this obligation will affect the legal and cost basis for the provision of primary care in Ireland.

Demand Effects & GP System Capacity

Naturally, if the removal of access barriers to primary care encourages greater use of primary care services, this will place additional demand on the primary care system itself. Even at current visiting rates, maintaining GP capacity is a significant challenge, particularly in some rural areas. A 2017 study of recent GP graduates in Ireland found that just under 20% had left the country; over 8% of those remaining had plans to emigrate, and a further 47% considered it as a possibility for them. In addition, just under 10% were not working in general practice or did not see themselves doing so in five years' time.³ Recruiting and maintaining medical expertise is a challenge across the health sector, however in the context of an increase in demand, capacity issues warrant careful consideration and planning.

3. Estimation of Private Expenditure on General Practice

Methodology

This note provides a secondary, or 'meta' estimation of GP private income based primarily on a review of previous analysis carried out in the area. Two types of information were reviewed: the first, which can be thought of as *bottom-up*, looks at estimations of the average *private visitation price*, that is the price charged to a patient who privately procures a GP consultation, and at estimations of the average private visitation rate, i.e. the number of times in a given period private patients attend a GP, on average. By estimating each of these components and combining them we arrive at an estimate of private expenditure on General Practice. The second group of information, *top-down*, simply reviews relevant metrics such as tax receipts and budget surveys, levels reported in the CSO System of Health Accounts. While we find some agreement among the various estimates, there is also considerable difference. Some of the possible reasons for discrepancies here are discussed, and we define a range which we feel can be argued to approximately represent the actual level of private expenditure on General Practice, with some confidence.

¹ Thomson, K. et al (2018) *The effects of public health policies on health inequalities in high-income countries: an umbrella review*. [\[Link\]](#)

² Connolly, S., Wren, M-A. (2017) *Unmet healthcare needs in Ireland: Analysis using the EU-SILC survey*.

³ Mansfield, G., Collins, C., Pericin, I., Larkin, J., and Foy, F. (2017) *Is the face of Irish general practice changing? A survey of GP trainees and recent GP graduates 2017* College of General Practitioners. Irish College of General Practitioners. [\[Link\]](#)

Findings

'Bottom-Up' – Estimation of Average Price and Visitation Rates

Looking first for estimates of the average price of a private consultation, recent data on GP prices in Ireland is somewhat limited. A number of surveys have been carried out in the last five to ten years, by public, private and academic bodies. These provide some indication, albeit they are slightly dated. Findings are reported in Table 2 below.

Table 2: Estimates of Average GP Private Consultation Price

Source	Price
The Competition Authority (2010) ⁴	€52.50
Household Budget Survey, as referenced in Wren et al. (2015).	"Similar to Competition Authority" ⁵
WhatClinic (2015) ⁶	€51
Brick et al. (2015) ⁷	€48

The Competition Authority, although the least recent of figures reported, is probably the most in depth survey of prices. This is verified by figures from the CSO Household Budget Survey, as referenced in Wren et al. (2015) who find a similar level. Furthermore, reports undertaken by WhatClinic, and Brick et al. find approximately similar levels, all around the €50 mark. **Given several years have elapsed since these studies were undertaken, during which prices in general were subject to upward pressure, and because these findings would appear to be lower than might be expected, particularly allowing for the inclusion of Out of Hours practice visitations, we elect to choose from the upper end of the samples. We therefore find €52.50 to be a reasonable estimation of average private GP consultation price in Ireland, when lacking evidence of a higher average consultation rate.** It should be noted however that this estimate is likely a lower bound.

Considering now, rates of visitation among the private population, while several sources are available which serve as useful indicators, each of the sources use different methodologies, sample sizes or survey slightly different populations, leading to a greater degree of variance in figures. The estimated rates are reported in Table 3 below.

⁴ The Competition Authority (2010). *Competition in Professional Services: General Medical Practitioners*. Available at: <https://www.ccpc.ie/business/wp-content/uploads/sites/3/2017/03/General-Medical-Practitioners-Report.pdf>

⁵ Wren, MA., Connolly, S. & Cunningham, N. (2015). *An examination of the potential costs of Universal Health Insurance in Ireland*

⁶ WhatClinic (2015). *Cost of a Private GP Consultation Survey*

⁷ Brick, A., O'Hara, S. & Normand, C. (2015). *Economic Evaluation of Palliative Care in Ireland*

Table 3: Estimates of Annual GP Visitation Rate

Study/Data Source	Rate	Data Source(s)
An Examination of the Potential Costs of Universal Health Insurance in Ireland (ESRI, 2015)	1.97	QNHS (2010), GUI.
Universal GP Care in Ireland: Potential Cost Implications (ESRI, 2018)	1.95 - 2.6	HI 2015, CSO QNHS (2010), GUI.
Medical Workforce Planning: Future Demand for General Practitioners 2015-2025 (McGovern & Morris, 2015)	2.12*	CSO QNHS (2010), GUI, CSO SILC, PCRS data.
Quarterly National Household Survey Q3 2010: Health Status and Health Service Utilisation (CSO, 2010)	2.35*	QNHS
Healthy Ireland Survey (2019)	2.9	HIS
Healthy Ireland Survey (2018)	2.4	HIS
Healthy Ireland Survey (2016)	2.6	HIS
Healthy Ireland Survey (2015)	2.9	HIS
<i>Average HIS for 2015, 2016, 2018, 2019</i>	2.7	HIS

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*Author Calculation based on Report

As noted in the third column of the above table, all estimations of visiting rate are based on survey data, namely the CSO Quarterly National Household Survey (QNHS), the Growing Up in Ireland survey (GUI), the Healthy Ireland Survey (HI/HIS) and the CSO Survey on Income and Living Conditions (SILC). A number of caveats around these sources must be briefly noted: notably, the age of participants questioned varies across studies; GUI surveys were conducted on infants and children (parents/guardians answered on their behalf). CSO surveys, such as for the QNHS and SILC interview only those aged 18 years and above. HI surveys gather responses on those aged 15 and above, however, the 2019 edition included details on GP visiting behaviour of those aged between 0 and 15. Methodologically CSO surveys ask respondents to provide the number of visitations in the previous 12 months, whereas HIS ask for the previous month; while the former may be less accurate due to more difficult recall, the latter may be subject to seasonal issues. Given no source provides a definite or completely representative estimate, we consider it appropriate to employ a range. We find it reasonable to estimate that a visiting rate of between 2.2 and 2.6 is broadly reflective of private patient visiting patterns.

As such our findings from this 'bottom-up' exercise are presented in the below table:

Table 4: Estimate of GP Private Income based on 'Bottom-Up' Approach

	Assumptions/Results
Average Consultation Price	€52.50
Visiting Rate for Private Patients	2.2 - 2.6
Average annual private spend on GP services	€115.50 - €136.50
Private population	2,831,293
Aggregate number of current private visits	6.23m – 7.36m
Annual aggregate private spend on GP services	€327m - €385.5m

⁸ Connolly, S., Nolan, A., Walsh, B. & Wren, MA. (2018). *Universal GP Care in Ireland: Potential Cost Implications*.

'Top Down' Approach: Other Indicators of GP Private Income

In addition to estimations of visitation rates and average consultation prices, other reference points exist which are reflective of the actual level of Private Expenditure on GP care. In terms of more fundamental data, estimates based on Revenue tax information provide some insight; these however are subject to some complexity due to the grouping of GP with other healthcare providers. The Household Budget Survey provides a survey based estimate from 2015, which requested respondents to outline the amount spent on GPs over a recent period; multiplying this out by the number of households provides another indicator of the total amount. Finally, work undertaken by the CSO in cooperation with Eurostat for the System of Health Accounts provides an informed estimate of out-of-pocket expenditure on General Practice. These are listed in the below table 5.

Table 5: Indicators of GP Private Income based on 'Bottom-Up' Approach

Source	Private Expenditure on General Practice
Revenue (2017)	€250m
Revenue (2015)	€246m
Household Budget Survey (2015/2016)	€184m
CSO System of Health Accounts (2017)	€188m

While subject to their own caveats, the above estimates provide a more direct and potentially more accurate picture of on private expenditure on General Practice. In addition, the level of disagreement between Revenue data and HBS/SHA is lower than it appears, for two reasons:

1. As mentioned above, the category into which General Practitioners fall on the Revenue Form 11 (tax return form) includes, small number of other healthcare professionals who would not be classed as General Practitioners, e.g. chiropractors.
2. Forms are completed on the basis of primary trade, thus instances may exist where Doctors undertake secondary work such as part-time farming (or have a spouse engaged in secondary work) and these would be included in the estimated income amounts cited above.

Discussion

Of immediate note is the scale of disparity between estimates derived from the two approaches (Table 4 and Table 5) which warrants further consideration. Taking the largest of the estimates presented from the 'top-down' view (Table 5), Revenue's €250m (itself an overestimate of GP income for reasons stated above), and now working backwards to reconsider average consultation price, we would see that assuming a mid-range estimate of visitation rate of 2.4 visits per annum, we arrive at an average consultation price of only €37, well below the estimates presented in Table 2. Similarly, reassuming our visitation price of €52.50 as previously taken, and reconsidering visitation rates, this would imply an actual visitation rate of 1.7, again well below estimates outlined in Table 3.

Given the directness of the top-down approach however, and reduced scope for error that it entails, we feel an obligation to heavily weight our estimations toward this lower end of the spectrum. In terms of resolving disparity however, we can offer three possibilities that would offset this gap to some degree:

1. While the 'bottom-up' approach took averages of consultation cost and visitation rate, it (by definition) does not allow for variations in either of these, which may exist on a regional basis. Assuming then that consultation costs are lower in some areas, e.g. rural practices, and

assuming these are attended at a higher rate, the top down approach would necessarily skew the estimation upward.

2. Secondly, and perhaps more importantly, part of the answer may lie in the tendency for some GPs not to charge for repeat consultations; this would allow for a visiting rate as cited above, however when related to expenditure on General Practice, the *effective* visitation rate would be significantly lower. This again would have the effect of overestimating private expenditure on General Practice via the 'bottom-up' approach.

Allowing for these above considerations as well as for the potential for price inflation over the ensuing years since these snapshots were taken, and placing greater weight on the veracity of top-down estimates, we estimate that a range of between €200m and €220m is a broadly accurate estimate of private GP expenditure.

4. Estimations of Demand Effects Resulting from Universal Free GP Care

While establishing the level of private expenditure on General Practice is by itself of interest in the context of normal GP arrangements for MC/GPVC holders, or in the context of need for emergency supports such as those provided in the initial weeks of the COVID19 response, the broader policy question which this note seeks to contribute toward is the appropriate reimbursement for GPs in the context of an expansion in free GP care. We can expect that a move toward free GP care would cause an upward shift in demand, as is indeed part of the rationale; the level of this shift however has repercussions for both an expected cost for Universal GP Care, and for planning around system capacity and functioning. This note will not provide any review on the latter issue, but suffice to say that significant work will be needed to adequately plan and ensure system capacity over the course of a move to Universal GP care.

Considering the question of the ‘demand effect’ or *price elasticity of demand* for GP services, several academic works have been undertaken in recent years, with consideration to the expansion of free GP care, in order to estimate its extent. A non-exhaustive list is presented in Table 6 below.

Table 6: Indicators of GP Private Income based on ‘Bottom-Up’ Approach

Study	Estimated current V.R.	Estimated V.R. (With universal GP care)	Increase in visiting rate (Increase in Visitations)	Data source(s)
Connolly et al. (2018) ⁹	3.08	3.81	Average increase for age categories provided = 1.05 (+34%)	Layte & Nolan (2016) – GUI Ma & Nolan (2016) – TILDA Nolan (2008) – LIIS 1995 – 2001 CSO QNHS Health Module 2010 HIS 2015
Wren et al. (2015) ¹⁰	1.97	2.9	0.93 (+18.2%)	GUI, TILDA, LIIS, CSO QNHS Health Module 2010.
McGovern & Morris (2015) ¹¹	3.08	3.81	0.73 (+23.4%)	CSO QNHS Health Module 2010, TILDA, GUI, CSO SILC, HSE PCRS
Behan et al. (2013) ¹²	3.35	5.06	1.71 (+51%)	Admin data from 6 non-randomly selected GP practices

Not unlike estimations of GP income, there is a relatively wide range in estimations of the expected increase resulting from a move to universal free care. The studies cited above estimate total GP visits would increase from 18.2% to 51% as a result of Universal GP Care. The listed studies vary in terms of their methodologies, data sources, and by extension sample populations; Nolan & Nolan (2007) for example only applies to those aged 16+; Wren et al by contrast, as with Connolly et al. (2018) and McGovern & Morris (2015) make use of a variety of data sets which range across the age spectrum.

⁹ Connolly, S., Nolan, A., Walsh, B. & Wren, MA. (2018). *Universal GP Care in Ireland: Potential Cost Implications*

¹⁰ Wren, M.A., Connolly, S. & Cunningham, N. (2015). *An Examination of the Potential Costs of Universal Health Insurance in Ireland*

¹¹ McGovern, E. & Morris, R. (2015). *Medical Workforce Planning Future Demand for General Practitioners 2015-2025*

¹² Behan, W., Molony, D., Beame, C. & Cullen, W. (2013). *Are Irish Adult General Practice Consultation Rates as Low as Official Records Suggest? A Cross Sectional Study at Six General Practices.*

Despite having gained widespread attention, the results of Behan et al. (2013) have been critiqued by Gorecki (2018), who notes that the findings are subject to upward bias, for reasons including:

- Administrative data from only six GP practices was used. These practices were non-randomly selected. This would not be expected to be a reflective sample of the Irish population.
- Methodology used in the study was not validated or reviewed independently by third parties.
- Behan et al. assume that when a private patient becomes eligible for free GP care, they will visit the GP as often as those who already hold a GPVC. This is unlikely to be the case given the comparatively better health and income status of currently private patients versus those who hold GPVCs.

Given the relatively large possibilities we feel it is prudent to again assume a range of possibilities, with weighting toward the lower end of the spectrum for reasons described above. As such we feel it reasonable to assume a move to Universal GP care will result in an increase of roughly 20%-40% among patients who are currently private.

5. Conclusion

While this note has reviewed available evidence on the current rate of private expenditure on General Practice, and on the likely demand effect of removing consultation costs for the private population, the actualisation of universal GP care will not necessarily be a straightforward transfer of funding source, and will be subject to many other considerations.

Based on the evidence reviewed here, we estimate that current private expenditure on GP care is in the region of €200m-€220m per annum, and that the demand effect of removing costs would result in an additional demand of 20-40% more consultations per year. Arithmetically it can therefore be said that the opportunity cost of free GP care is in the region of €240m-€308m per annum. While this is useful information, it is undoubtedly a simplification of a more complex reality. As noted earlier, an increase in demand cannot simply be purchased without consideration of capacity in the overall system. Such a change in the structure of General Practice in Ireland would likely imply a reworking of the model of care which is developed and provided to citizens, which would likely have complex cost and structural effects in terms of what is delivered and how it is delivered. Furthermore, moving from a semi-private to fully public system would necessarily require an alternative model of employment between GPs and the State, the terms of which would naturally be subject to negotiation. Finally it does not automatically follow that the full costs of GP care provision will be covered solely via the Exchequer on current tax arrangements; many countries fund or partially fund healthcare via a higher rate of healthcare related taxation (PRSI in Ireland), and/or through co-payment models.

While a previous paper as published by the DPER Health Vote last year found the cost of Universal GP Care would be in the region of €630m on the current terms of Medical and GP Visit card holders, this opportunity costing serves as a useful counterbalance, which should be fully considered given the health differences, and thus healthcare needs which exist between currently covered and uncovered populations.

Quality Assurance process

To ensure accuracy and methodological rigour, the author engaged in the following quality assurance process.

- ☒ Internal/Departmental
 - ☒ Line management
 - ☒ Spending Review Steering group
 - ☐ Other divisions/sections
- ☒ External
 - ☒ Other Government Department
 - ☐ Other Steering group
 - ☐ Quality Assurance Group (QAG)
 - ☐ Peer review (IGEEES network, seminars, conferences etc.)
 - ☐ External expert(s)
- ☐ Other (relevant details)



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Phoiblí agus Athchóirithe**
Department of Public
Expenditure and Reform

Tithe an Rialtas. Sráid Mhuirfean Uacht,
Baile Átha Cliath 2, D02 R583, Éire
Government Buildings, Upper Merrion Street,
Dublin 2, D02 R583, Ireland

T:+353 1 676 7571
@IRLDeptPer
www.per.gov.ie