1240/5(7380)

WRITTEN QUESTION TO THE MINISTER FOR SOCIAL SECURITY
BY DEPUTY M.R. HIGGINS OF ST. HELIER
ANSWER TO BE TABLED ON TUESDAY 29th JANUARY 2013

Question

Further to my written question 1240/5(7300), dated 11th December 2012 regarding Health Insurance Fund payments to doctors, will the Minister:

(a) explain whether a similar check to that requested in the original question has previously been carried out by the department and if not what checks and balances have been made in this area;
(b) explain the reasons why nine or more doctors are claiming more than £100,000 per annum for patient consultations in 2011;
(c) explain the reasons why 22 or more doctors are claiming more than £15,000 per annum for referral letters in 2011;
(d) why certain doctors have had significantly high consultation and referral payments over the three years examined;
(e) why doctor 41's level of consultation fees and referral fees appear to be physically impossible on the basis of a normal working week and number of consultations per day?

Answer

Whereas question 7300 did not explicitly refer to the checks and balances provided by my Department in respect of Health Insurance Fund payments to local GP practices, I can reiterate the information provided in response to question 7223 (asked by Senator Ferguson on 20 November 2012). This stated that:

"Claims are checked automatically using embedded business rules within the Department's IT system before processing and invalid claims are rejected, according to those business rules. These rules include automatically rejecting multiple claims for the same consultation and alerting the Department if a patient has more than one visit/claim within 24 hours from a single surgery. In the latter scenario, payment is not made unless the surgery can confirm that it is a genuine instance of 2 separate claims. When claims are rejected, this information is provided to the GP, as each batch of claims is paid.

In addition to these automatic checks which are applied to every claim submitted, the Department undertakes periodic random checks on claims by confirming details with the individual patient, by either letter or phone call. The Department also writes directly to surgeries, again on a random basis, to confirm details of claims. Checks are also specifically undertaken in respect of patients with high numbers of consultations.

A Medical Director has recently been appointed to lead the Primary Care Governance Team and he has already undertaken a number of visits to local practices to ensure that best practice is being followed and has initially focussed upon practices with high levels of consultation or referral letters

Between 1 October 2011 and 30 September 2012 2,438 claims were disallowed.

The claims submitted by GPs include information on the identity of each patient and the date and time of their consultation."

The variation in the level of payments demonstrated in the tables attached to answer 7300 relates to the variation in the level of activity as undertaken by individual GPs. GPs in Jersey operate as private businesses and are free to practise on a part-time or full-time basis. Within practices, some GPs will work longer hours than others. During the period in question some doctors may have been on maternity leave, sabbatical or sick leave, therefore the figures should be interpreted with caution.

I can confirm that the information provided with question 7300 included 10 GPs showing a total in excess of £100,000 for medical benefit claims in 2011 in respect of consultations. It also included eight GPs showing a total of less than £40,000 for 2011. The information identified 15 GPs with medical benefit claims in excess of £15,000 for referral letters in 2011, and a further 15 with claims of less than £5,000. These details are based on the information submitted by GP practices.

As noted previously, there will be significant variations in funding received for several reasons including:

- The total number of hours worked per GP;
- Number of consultations offered per hour
- Knowledge base – some GPs with a particular knowledge of some aspect of general practice may see more patients in that area
- Ancillary services offered – e.g. minor operations might reduce the number of claims for HIF benefit in comparison to other GPs as these procedures result in longer consultations
- Amount of annual leave taken (varies between practices and between individual GPs)
- Some GPs see patients with a higher morbidity index (i.e. are sicker than others) - and therefore will generate more rebates as their patients need more care.
- Characteristics of the patient list for each GP that will affect the number of consultations include
    - age
    - disease
    - co-morbidity
    - health-seeking behaviour (some patients are more dependent than others)
    - social situation

- Some GPs are more actively involved in providing population services such as screening and immunisations

- The proportion of work undertaken by the GP that receives funding from the Health Insurance Fund - some services provided by GPs do not qualify for health insurance rebates.

In addition to the above factors, referral rates can also vary for a variety of reasons including:

- Knowledge base of doctor (there is evidence to suggest that doctors who have more skills in a subject may refer more patients than a doctor who is less skilled). GPs are trained as generalists and they are responsible for making appropriate referrals.
- Clinical need - particularly with ageing population
- Patient expectation
- Obtaining access to secondary care medication or investigations e.g. MRI scans.

I can confirm that the high amounts attributed to doctor "41" in the previous answer result from an administrative error within a GP practice which led to claims from two separate GPs being submitted using a single code. This administrative error did not affect the total amount of money claimed by the practice. The Department receives claims for medical benefit in batches from GP practices, and not from individual GPs. These claims are checked as described above, and then a payment for the whole batch is made to the practice. The Department does not make medical benefit payments directly to individual GPs.

The Department has been working closely with the Primary Care Governance Team, the Primary Care Body and individual GP practices over the last few months, since the appointment of the Primary Care Medical Director, to improve the information available in respect of GP governance. This is part of a major project which began in 2010 to ensure that GPs in Jersey are working within a well regulated environment and able to meet the revalidation requirements of the UK General Medical Council.

The Primary Governance Team (PCGT) is working with GPs and practices to introduce a comprehensive governance programme. This will allow GPs to demonstrate to the UK General Medical Council that they are up to date and fit to practise. It will also provide assurance to Jersey patients that GPs are continuing to work to the highest standards.

A programme of practice visits has been introduced by the PCGT. GPs will continue to have an annual appraisal (and have done so for the last 3 years). They will now also produce information to show how they are improving the quality of their practice. They will need to show how they keep up to date and ask for feedback from patients and colleagues and agree an annual personal development plan.

Patients will not want doctors to be taken away from the time they spend with patients, so the governance framework will focus on those issues that are most important for patient care and will seek to ensure that all GPs are reflecting on their practice.

There is a close connection between clinical and financial governance and the improvement in the clinical governance of local GPs will allow enhancements to be made to the existing financial governance structure.