HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

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I would like to address a number of issues which I believe to be at the heart of shaping primary care in the future.

Continuity

The principle of continuity of care provided by family doctors lay at the heart of the Highlands and Islands Medical Scheme of 1913, the Cathcart Report of 1936 and the four National Health Service Acts of 1948 and it’s a principle that remains important today.

The Royal College of General Practitioners (RCGP) has defined continuity of care as ‘as the extent to which a person experiences an ongoing relationship with a clinical team or member of a clinical team and the coordinated clinical care that progresses smoothly as the patient moves between different parts of the health service. Continuity of care is a critical element of general practice, particularly, continuity of the personal relationship between patients and their general practitioner. Many patients are looking to general practice as the keepers of their story, the clinician or team of clinicians that know them and their circumstances’

A paper published in the BMJ in 1973 looked at a domiciliary outreach service provided by the St Christopher’s Hospice, London and reviewed hundreds of cases over three years. The conclusion was blunt – ‘the most important factors contributing to the success of the service are continuity of care and good communication – without this the whole thing falls’

Yet by the mid-1990s continuity of care was clearly in trouble. Another BMJ paper, published in 1995, concluded that ‘continuity of care in general practice is a dying concept, while for hospital consultants it has probably not existed for some time’

So how did we get there?

When I was a junior doctor working in hospitals in the late 1980s and early 1990s I worked under the model colloquially referred to as ‘the medical firm’. Each firm consisted of a named consultant and, working under them, a consistent set of junior doctors at various stages of training – usually a junior house officer, a senior house officer, a registrar and, often, a senior registrar. When you were on-call you were on with your whole team and any patients admitted during your on-call were the responsibility of your team until they were discharged. As such there was continuity of care. There was no need for the patient to repeat their story a dozen times. There was no ‘passing the buck’ to the next shift (as a house officer I did not leave the ward until all my patients were sorted and stable ready for me to pick up the next
morning). There was no doubt about what the investigation and treatment plans were. Moreover, once the patient was discharged if they needed to be followed up in out-patients the same team would see them in the out-patient clinic.

In 2005 all that changed with the introduction of Modernising Medical Careers (MMC). This was aimed at ‘developing a flexible workforce of doctors, competent at dealing with the acutely ill patient and effective at communicating with both patients and colleagues’ and left us with the system we have now – junior doctors working in shifts and a loss of continuity.

A paper in the BMJ in 2008 bemoaned the situation where ‘continuity has been particularly neglected by recent policy despite the high value placed on it by many patients’ and a survey done by the Royal College of Physicians in 2012 found that 28% of hospital consultants felt their hospitals’ ability to deliver continuity of care was poor or very poor. It is likely that if that survey was repeated today this percentage would be substantially higher.

Meanwhile in general practice things have changed too. In 2004 GPs were given the option of opting out of their traditional obligation to be available to their patients 24/7. It was hardly a surprise that the vast majority of GPs took that option. To be fair, however, had that change not come about it is likely that general practice in many communities (particularly less urban ones that did not have access to GP cooperatives for out of hours care) would have collapsed.

Another major change is that the number of professionals involved in your primary care has increased significantly and has become more varied. In your health centre or doctors surgery you will now be looked after by GPs, practice nurses, healthcare assistants and community pharmacists. There may even be a counsellor or physiotherapist thrown into the mix. In addition we are seeing the rise of ‘super practices’ caring for tens of thousands of patients. Such scale makes continuity more challenging. The GP workforce itself has changed too with many more GPs now working part-time.

At the same time politicians have promoted populist proposals aimed at making access more convenient without thinking about the impact that this might have on continuity. While increased access need not necessarily have a detrimental effect on continuity the evidence suggests that it often does.

The concept of walk in primary care emergency centres was first put into practice in North America in the late 1970s. But a review looking at two decades of such primary care walk in centres in Canada published in 2000 concluded that ‘the most concerning finding is the lack of continuity…which may have important long-term cost and quality implications’
One of the side effects of encouraging easier access is that there has been a significant rise in hospital admissions in Scotland and the rest of the UK in recent years and this rise is largely down to people self-referring to A&E departments or calling the ambulance service directly rather than as a result of increased referrals from GPs.

So why does any of this matter? If you can get seen when you want by qualified professionals and have your problems dealt with why does continuity per se matter?

The evidence suggests that continuity matters because, at its most prosaic level, it improves patient satisfaction. But there are even more profound benefits which continuity can offer. It can avoid unnecessary investigations, it can reduce referrals to A&E departments and it can prevent hospital admissions.

It is also linked to improved mortality benefits for the elderly, better quality management of long-term conditions such as diabetes and the earlier detection of cancer (with presumed better outcomes for these patients).

So, if we really want to reduce costs and improve outcomes, it is time to make continuity of care once again ‘a doctrine of the highest importance’ and ensure that it lies at the heart of the planning for healthcare delivery in Scotland in the future.

**Universalism**

The NHS in Scotland delivers 17 million GP appointments a year – the equivalent of between 3 and 4 GP appointments for every person living in Scotland.

And yet it is still not enough. Primary care is suffering a perfect storm - more GPs are leaving the profession than entering it, driving major recruitment and retention problems, at the very time when general practice has become more demanding and more complex than ever before as our population ages and more care is shifted from hospitals into the community.

And things are not much better in our hospitals. Throughout Scotland the traditional district general hospitals found in many larger Scottish towns cannot recruit enough Consultants - or enough nurses, physiotherapists, radiographers, lab staff, catering staff, cleaning staff, etc.

These problems with recruitment and retention are not unique to Scotland – they are apparent across the developed world and in every continent.

As a consequence there must be a change to the level of services provided and a change in the way these services are delivered. In October 2017 Audit Scotland published its annual review on the state of NHS Scotland. They were frank in their assessment:

‘We have reported many times on the challenges facing the NHS including increasing costs, growing demand, and the continuing pressures on public finances.
In 2016/17, these challenges continued to intensify. Demand for healthcare services continues to increase and more people are waiting longer to be seen. For example, the number of people waiting for their first outpatient appointment increased by 15 per cent in the past year and there was a 99 per cent increase in the number of people waiting over 12 weeks. Scotland’s health is not improving and significant inequalities remain, while general practice faces significant challenges, including recruiting and retaining GPs and low morale. In the face of this, NHS staff have helped maintain and improve the quality of care the NHS provides. Yet there are warning signs that maintaining the quality of care is becoming increasingly difficult. The findings in this year’s report illustrate why the way healthcare is planned, managed and delivered at all levels in Scotland must change.

Their prescription is challenging – services need to change significantly in terms of how and where they are delivered but this is a very complex undertaking that will take a long time. But they are equally clear that ‘approaches such as providing more funding to increase activity or focusing on specific parts of the system are no longer sufficient’ and they are calling for long-term financial plans (rather than an annual budget) and widespread cultural changes – political, professional and societal – and they are clear it is time to ‘move on from statements of intent to developing the specific actions’.

Alternatively we can substantially increase funding.

Over the last few years the Royal College of General Practitioners in Scotland has called for the funding of general practice to increase by about 3% – roughly an extra £500 million. However, if this is to come from the existing NHS Scotland budget it will only diminish the share of the budget available to hospitals and others parts of the NHS.

Yet NHS boards are seeing increasing pressure on their budgets due to rising hospital costs – the increasing wage bill, the rise in hospital drugs bill (by as much as 16% per annum), and higher energy costs.

If more money is to go to general practice but hospitals are not be financially disadvantaged as a result then the only alternative is to increase the overall level of funding. But if this has to be done within the existing Scottish Government budget then that means reduced spending for other areas such as education, housing, transport, etc. So the only fair way to address the problem is through an increase in general taxation whilst accepting that any increase in tax revenue will have competing demands placed on it by social care, education, transport, housing, and local authorities.

The Chartered Institute of Taxation (CIOT) in Scotland issued a press release addressing the likely consequences of Scotland’s new tax raising powers: ‘Scottish income tax decisions may face limitations. Having control over some parts, but not others, of a complex interacting tax system may limit the Scottish Parliament’s ability
to maximise the use of its income tax raising powers. Income tax is only partially devolved, and Holyrood does not have control over some key aspects of the income tax system – such as the tax base (deciding who and what can be taxed), the tax-free personal allowance, and income tax on savings and dividends. Corporation Tax (the tax on company profits) and National Insurance contributions are likewise reserved to the UK Parliament'. In other words whatever the Scottish Government decides to do it will continue to have one hand tied behind its back.

But for me the issue is more fundamental and the decision rests not with political bickering but rather it requires, as Audit Scotland hinted at, a societal change and a societal decision.

To my mind the question is simple and profound – do we, as a society, believe in and want to support the concept of universalism in healthcare?

What do I mean by universalism?

The Second World War brought about a sea change in social attitudes in Scotland and the rest of the UK. Calls were made to tackle privilege and create a more equal society. The Beveridge Report (1942) proposed a welfare state to which everyone who could would contribute and from which everyone would benefit according to their needs. Beveridge supported the idea of flat-rate contributions in return for flat-rate benefits. What this meant for healthcare was that it should be freely available to all at the point of access, paid for from central taxation.

The desire, or otherwise, for universalism in healthcare provision is, I believe, at the root of the current debate on the future of the NHS in Scotland. Some political parties are still instinctively opposed to universalism whilst other parties almost never mention the word. Yet the concepts of universalism were adopted quite widely and very successfully by the Nordic nations in the 1960s and 70s. Sweden, for example, has consistently rated among the best healthcare systems in the world. It achieves this, in part at least, by consistently spending a higher proportion of its GDP on healthcare than any other country, although even there things are starting to be scaled back.

There is a persisting myth in Scotland and the rest of the UK that by paying tax and national insurance now you are somehow storing up credit for the future. But this is not true. We don’t have a trillion dollar sovereign fund. Today’s tax revenues are simply paying for today’s health service in the vain hope that tomorrow will look after itself.

It is my belief that universalism provides the most efficient and cost-effective means of giving access for all to the top quality healthcare they deserve and, as things stand, we are at serious risk of losing that. Any alternative will always ultimately punish people for being ill. As a doctor I find that unacceptable.
But the only way we can preserve universalism is through higher taxes and a change in our way of life. We cannot keep saying no to politicians who want to increase our taxes. And we cannot continue to demand the right to own multiple homes, multiple vehicles or multiple belongings and have multiple annual foreign holidays and then demand that health and social care are provided free of charge at the point of use.

Realistic medicine

The ultimate aim of healthcare is to reduce illness and avoidable death and improve our quality of life. But sometimes modern health services do the opposite. They subject people who don’t need intervention to investigations that they don’t need; they label them as being ill or at risk of something; they provide unnecessary treatments and therapies; they tell them to alter their lifestyles; they persuade them that they need regular monitoring. And once we have frightened someone it is very difficult to take that fear back.

These activities do not improve things. Instead they can result in complications, illness or even death, and they reduce the quality of life. In other words, modern medicine can actually subject us to too much medicine – what is also referred to as over-diagnosis and over-treatment.

But what this actually boils down to in the end is a failure by both professionals and the public to accept one of the fundamental features of illness and healthcare – uncertainty. And addressing this widespread “intolerance of uncertainty” will not be easy.

As Iona Heath, the former President of the Royal College of General Practitioners puts it “Uncertainty exists in the gap between the territory of human suffering and the map of biomedical science. The task of making the medical map useful to those trapped within the territory of suffering is, and will always be, fraught with uncertainty because of the vast extent and infinite variation of the territory and because of the comparatively rudimentary nature of the map”.

We have come to believe that modern medicine, and the science which underpins it, are perfect and infallible and therefore any ‘error’ or ‘adverse event’ is a failure, the assumption being that a bad outcome reflects poor care rather than any inherent uncertainty.

Doctors are left feeling guilty and ashamed when harm occurs and patients are left feeling angry and litigious. As a consequence doctors move further towards a position of ‘defensive medicine’ which brings with it more tests and more interventions.

Medical litigation tends to punish omissions rather than actions – doctors more often get sued for not doing something than for doing something. The natural defence against this is for doctors to do more.
Nowhere is this behaviour more apparent than in the USA. The USA spends twice as much per head of population on diagnostic interventions than countries like Scotland yet with no obvious clinical gain to show for it.

Yet what we really need is the right healthcare not more healthcare. Simply because we can do more does not mean that we should.

Doctors are by nature driven to intervene and treat and tend to be more focused on what can be done rather than the outcome of such intervention. They also tend to down play risks and side effects.

They also feel a degree of compulsion forced on them by a growing epidemic of clinical guidelines despite estimates suggesting that as many as two thirds of these guidelines are of uncertain relevance to primary care, the environment in which 90% of healthcare in Scotland is delivered.

But when forced to choose for themselves doctors choose less treatment than they do for their patients. Moreover when patients are better informed about risks and benefits they too choose less treatment, tend to experience less regret and tend to have fewer side effects even if they do go ahead with treatment.

And, of course, every time we spend money on interventions offering little or no benefit we are reducing the spending on activities which do actually work.

The fundamental conflict we are faced with is that we are trying to use technical solutions to solve existential problems. Giving the 2012 Jefferson Lecture the American writer, Wendell Berry, put it this way:

“The problem that ought to concern us first is the fairly recent dismantling of our old understanding and acceptance of human limits. For a long time we knew that we were not, and could never be, ‘as gods’. We knew, or retained the capacity to learn, that our intelligence could get us into trouble that it could not get us out of. We were intelligent enough to know that our intelligence, like our world, is limited. We seem to have known and feared the possibility of irreparable damage. But beginning in science and engineering, and continuing, by imitation, into other disciplines, we have progressed to the belief that humans are intelligent enough, or soon will be, to transcend all limits and to forestall or correct all bad results of the misuse of intelligence”

The American philosopher, Daniel Callahan, talks of the ‘difficult child of medical progress’ – longer lives, more suffering and slower deaths.

When GPs cure something that cure is usually obvious and quick. But much of the time primary care is not about curing. Rather, as Professor Graham Watt, Professor of General Practice at Glasgow puts it “it’s about stopping people getting worse faster and dying sooner”.

But medicine continues to intervene. Somewhere in the region of 8 – 10,000 coronary stent procedures are done each year in Scotland. Such intervention does reduce suffering from angina – but it does not prolong life. In Scotland we also carry out screening for aortic aneurysm – but this does not appear to reduce overall mortality (and the procedures that can be triggered by it have potentially major and devastating consequences).

One of the worst areas of over-treatment is at the end of life.

Chemotherapy is often given in people with terminal cancer in an attempt to improve their quality of life. But research published in the JAMA Oncology journal in July 2015 actually demonstrated that “the quality of death in patients with end-stage cancer is not improved, and can be harmed, by chemotherapy use near death, even in patients with good performance status”

Another study carried out in America and published in the New England Journal of Medicine in 2010 compared patients with metastatic lung cancer who were offered early palliative care rather than the standard treatment with chemotherapy. They found that those who opted for the early palliative care and did not have the chemotherapy lived longer and had a better quality end of life.

And when studies have been done looking into the success of carrying out cardio-pulmonary resuscitation (CPR) in patients with metastatic cancers they have found that no-one survives.

The Chief Medical Officer for Scotland’s annual report published in January 2016 signalled a clear change of direction at the highest level. It was entitled ‘Realistic Medicine’ and it called for us all to tackle the issues around over-diagnosis and over-treatment. The Scottish Government has recognised the issues in its latest National Clinical Strategy.

The National Institute for Health and Care Excellence (NICE) has now produced a list of over 900 interventions that doctors should not do. And in America the American Board of Internal Medicine has its ‘Choosing Wisely’ initiative, which now adopted by nine countries and which again lists hundreds of interventions which should not be done and which should be questioned by both doctors and patients.

Some countries have taken it a step further and introduced ‘community juries’ to adjudicate on controversial issues. In Australia this resulted in a recommendation to the Australian Government not to invest in PSA screening for prostate cancer.

The Welsh Government has introduced the concept of ‘Prudent Healthcare’ which aims to provide “Healthcare that fits the needs and circumstances of the patient, and avoids wasteful or harmful care”
Telecommunications

The Dewar Committee Report of 1912 led to the formation of the Highlands and Islands Medical Scheme which itself formed the blueprint for the NHS over 40 years later.

One of the issues highlighted by the Report was the poverty of telecommunications in rural areas – “There is abundant evidence to show that liberal extension of telephone communication in connection with the medical service would be a great public boon, and pre-eminently in the case of insular and remote centres where a trained nurse is stationed. She could discuss a case with the doctor and take his detailed instructions. At present efforts are often made to communicate by telegraph, which for purposes of medical inquiry and advice, is cumbersome and unsatisfactory. The Committee were surprised to be told that the Post Office was contemplating the withdrawal of telegraph service from some of the remote Western Islands. We strongly deprecate any such action”

Sadly 100 years later perhaps not much has changed. The Ofcom report ‘Connected Nations 2015 (Scotland)’ found that “it remains the case that the individual nations of Scotland, Wales and Northern Ireland, as well as rural England, see lower availability of communication services”.

Dr Andrew Inglis, a Consultant in Emergency Medicine who works for Scotland’s Emergency Medical Retrieval Service, says “a modern reliable mobile phone network across remote and rural Scotland would benefit the NHS in terms of improved quality of healthcare and reduced costs. The use of phone, camera, video and computer technology can enhance the delivery and sustainability of locally delivered care with savings in time and cost. Rural general practice is challenging with recruitment and logistics difficulties. Communication is a key issue. Out-of-hours cover for remote general practice can be problematic and many rural areas have concerns regarding emergency ambulance provision”.

There is a growing body of evidence from across the world as to the value of out of hospital photographic and video links e.g. with road traffic accidents and other case of trauma, dermatological conditions, etc.

In addition, the ability to transmit data remotely can be invaluable – a cardiograph in someone with chest pain or the home monitoring of someone with a chronic medical condition – reducing the need for costly and time consuming visits to hospital clinics and allowing early intervention from local primary healthcare teams. A project in the Western Isles showed that the use of such technology reduced appointment cancellations and as a result reduced travel costs for visiting consultants.

A poor rural mobile network prevents communities from taking advantage of these advances in technology and ends up costing the NHS more.
In 2015 the Scottish Government, working in partnership with COSLA, BT, Highlands & Islands Enterprise and the EU Regional Development Fund, launched an ambitious £412 million project aiming to extend high speed broadband to around 95% of Scotland by the end of March 2018. But a target of 95% of the population still excludes quarter of a million people.

Caroline Gardner, Scotland’s Auditor General said “It’s encouraging to see good progress being made in rolling out fibre broadband. However, there is a lot still to be done by the Scottish Government if it is to achieve its vision of a world class digital infrastructure, particularly in improving download speeds in rural areas. It’s important that it continues to monitor the cost and progress of broadband rollout so that these communities aren’t excluded”.

There is also another potential ‘dark spot’ on the horizon over which Scottish Government has no control.

The Emergency Services Network (ESN) is the means by which emergency services communicate within and among themselves. The UK Government put the current Airwaves service up for tender and awarded the contract for providing a new system to EE – a company which recently advised some customers in rural Scotland to switch to alternative providers as they could no longer guarantee a service in their locality. It’s clear that if EE are to match the existing Airwave service they will have to significantly improve their current level of remote rural coverage.

Those working in remote rural healthcare can look with some degree of envy at other parts of the world.

In Labrador, Canada tele-health via 3G wireless is provided to all remote communities and between a general hospital in Goose Bay and a specialist hospital in St Johns, Newfoundland. This service is available 24 hours a day, 365 days a year. The emergency department in Goose Bay uses tele-health to support the management of cardiac arrest or major trauma by remote teams on the ground. The Labrador tele-health system also supports primary care in the management of acute and chronic disease and provides access to specialist opinion. The service is felt to save money and save lives.

Meanwhile remote rural healthcare workers in Queensland, Australia use telemedicine as a routine part of their medical practice. Tiny Thursday Island in the Torres Strait routinely uses telemedicine to link with specialist centres over 1000Km away.

And a conference held in Inverness recently heard how a community-led health service uses telecommunication to support healthcare assistants to provide services to remote Alaskan communities sometimes with as few as 20 households; in northern Sweden the remote area of Norrbotten, an area larger than Scotland but with only quarter of a million people, has universal 4G coverage; the Peruvian part of
the Amazon basin mobile phones, charged with solar energy, are being used to help local women to provide healthcare in their own villages; in Kenya nomadic people are using mobile phones to access healthcare consultations remotely; and in Rwanda they are aiming to provide 4G coverage to over 95% of their population to allow a new generation of doctors and healthcare workers to work in remote parts of that country.

Dr David Hogg, a GP who worked for a number of years on the island of Arran, has been one of the main movers behind attempts to improve connectivity in that part of Scotland. He says “Connectivity now defines access. There are so many things I could do from my laptop – access patient records, change medications, read results, look at X-rays, providing and receiving mentoring and professional support – but connectivity is an absolute necessity to make this happen. Connectivity (and the lack of it) is driving global health inequalities, especially in rural areas. The challenges (and opportunities) of integrating health and social care here in Scotland, along with harnessing the benefits of connectivity in surmounting the difficulties of geography and distance seen in rural areas, is too great for us to miss”.

British Telecom recently launched a trial project covering only 20 household in the Township of North Tolsta in Lewis. A new technology, Long Reach VSDL, aims to overcome the loss of speed caused by the long distances from the fibre cabinet to the end users.

Other rural communities in Scotland are taking matters into their own hands. The local community development trust on the island of Coll have teamed up with the Scottish Futures Trust and Vodafone to have a community-owned mast providing 3G and 4G signals for the island as an alternative solution to the provision of broadband.

In Argyll a community-led and community-owned project, GigaPlus Argyll is being supported by Highlands & Island Enterprise in their attempts to download speeds from 2Mb/s to as much as 50Mb/s in Colonsay, Mull, Iona, Jura, Islay, Lismore and Craignish.