HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM PHILIP WILSON DPhil FRCPCH FRCGP

I write this as a general practitioner with 32 years’ experience and as a clinical academic for the past 24 years. I am currently professor of primary care and rural health at the University of Aberdeen and visiting professor of child health in general practice at the University of Copenhagen, as well as working as a GP in Inverness. I am also the research lead for the Rural GP Association of Scotland but write this in a personal capacity.

I have been involved in the development and evaluation of many initiatives designed to improve the quality and scope of primary care in both urban and rural settings in Scotland and internationally, and my clinical work in Glasgow and Highland has been with very diverse populations.

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?

The work of the public panels was excellent and most of the recommendations are sound. There were nevertheless a number of methodological weaknesses with the online survey which generated some of the recommendations in the H&SC report. The sample size was small and probably unrepresentative, and there were some leading questions about, for example, GP independent contractor status which would almost certainly not be adequately understood by most respondents.

The following sections will address the changes that are needed to meet the priorities of local communities which include delivery of effective, affordable, integrated, accessible, equitable and personalised care near to home.

Shifting the balance of care.

There can be little doubt that the key change required is a major shift of activity from acute hospitals to primary care. Although many policy-driven attempts have been made over the years to deliver a greater proportion of care outside acute hospitals, almost all have failed dismally. Acute admissions, for example, have risen inexorably since 2004/5, after years of stability, in parallel with other elements of hospital activity such as emergency department attendance.

Demographic change can explain only a small part of the increase in hospital activity, which is likely to be attributable to several factors based in primary and secondary care as well as to broader societal factors such as media coverage of health issues and the regulatory environment. It is not possible to disentangle the impact of these factors completely, and solutions which might allow creation of a more rational and effective primary care service will require whole system changes.

Something clearly went seriously wrong with the balance of care after 2004/5 and it is worth considering potential underlying factors in order to consider remediation. 2004 saw the introduction of a new GP contract which increased practice incomes temporarily but which shifted the focus of care, through financial drivers, towards individual chronic disease management and arguably a less holistic approach to care. The contract also freed GPs from responsibility for out-of-hours work. At the same time, the close links between general practices and the core community health services offered by health visitors and district
nurses were broken following the disbandment of Local Health Care Cooperatives (LHCCs). Before considering any suggestions for substantive change, it is important to analyse the factors which have driven the current problems with the balance of care.

General practice is the only part of the NHS in Scotland which has seen a real-terms decrease in its funding since 2004. The proportion of NHS expenditure spent on general practice has dropped over the same period from around 9% to less than 7%.

Expenditure on hospital care has increased massively since 2004, with some benefit to patients. Nevertheless, much of this resource has been dedicated to providing expensive care of questionable benefit (e.g., some palliative chemotherapy) to older patients in the last weeks of their lives. Recent worsening mortality statistics support the view that investment in hospitals has failed to produce substantial population-level benefit. Increasing hospital specialisation has reduced the holistic perspective on patient care, and a further consequence is that the interface between primary and secondary care has become much more problematic. The ratio of consultant to GP numbers has increased from around equality to 1.4:1.

Assuming that overall NHS expenditure will not increase, remediation of many of these problems will require a relatively small percentage reduction in hospital expenditure and a substantial increase in expenditure on general practice. Implementation of the first of these will not be politically easy, and will require strong leadership.

Re-integration of primary care teams

In the 1990s, it was commonplace for district nurses and health visitors to be co-located with GPs. I used to meet our health visitor and district nurse most days as a GP 20 years ago, but have hardly ever seen a health visitor or district nurse in my practice for the past seven years. This experience can be generalised throughout the UK. This disintegration of primary care services cannot be helpful for patients. At the same time as general practice and community services have become fragmented, expenditure on the community services has increased substantially. In parallel with the situation with hospital spending, the health benefits of this increased resource allocation are not obviously proportionate to the expenditure.

Remediation of this highly unsatisfactory situation requires strong policy leadership. In my view, the re-establishment of a model based on the LHCCs which existed from 1999 to 2004 would be the preferred approach. This model was in essence that of a cluster of practices in which the practices were given collective responsibility and resources to manage core community services such as health visiting and district nursing, as well as for limited locality-appropriate initiatives. One weakness of the LHCC model was the lack of integrated public health expertise to guide resource allocation decisions, and this would be desirable if the model was to be revived.

Focus on personal continuity of care

Patients value personal continuity of care, and this is echoed in the Panel reports. Continuity provides benefits to the NHS as a whole, and allows more efficient care because a clinician who knows a patient understands the complexity of their medical and social circumstances as well as their personal preferences better than one who does not, avoiding the need for ‘going over old ground’ repeatedly. There is now irrefutable evidence that personal continuity of care is associated with improved life expectancy. The recent trend towards multiple routes of entry into primary care through the expanded multi-disciplinary team – a necessity which seems to have become transformed into an ideology in some quarters – may have reduced personal continuity of care and it requires evaluation (see
below). In most circumstances, the GP (assuming there are sufficient numbers with short waiting times), trained to have a broad bio-psycho-social perspective, is best placed to be the first point of contact for most conditions. Routinely available recent data from Health Board run practices in Caithness, where there has been a sustained effort to replace GPs with non-medical professionals, have revealed exceptionally low levels of patient satisfaction as well as high costs.

One key issue in relation to continuity of care is the provision of out-of-hours primary care which was a practice responsibility until 2004, often delivered by local GP cooperatives or ad-hoc groups of practices. Current arrangements offered by NHS24 are much more costly and much less satisfactory in terms of continuity than the GP-co-operative approach which was prevalent in the 1990s. Our work on the Glasgow Emergency Medical Service at that time suggests that its overall costs were a small fraction of current expenditure and levels of satisfaction were very high. Assuming adequate numbers of local GPs could be persuaded to offer care, reinstatement of a well-funded GP-led out-of-hours service would be highly desirable. This would require some GPs currently working exclusively out of hours to re-enter mainstream practice.

Make it attractive to be a GP independent contractor again

In the 1980s and early 1990s, most GP partnership vacancies had 50+ applicants. Now it is uncommon to have more than a handful, and often there are no applications. In my year of graduation (1983), many, or possibly most, of the brightest medical students wanted to be GPs. The situation now is that, across the UK, around 17% of medical graduates commence training in general practice, while the figure needs to be close to 50%. There is a large body of literature about this subject, and Prof Wass’s report ‘By choice - not by chance’ distils this in a useful way. Her proposed solutions, which include a strong commitment to the growth of academic general practice, are worthy of support in Scotland.

The independent contractor model has been the mainstay of general practice since 1948. It is the dominant model in North West Europe where its value is rarely questioned. The independent contractor model, in which the clinician partner commits to involvement in all aspects of general practice provision for his or her registered patients, is highly cost-effective and encourages adaptation of services to local circumstances. The independent contractor model has been in decline in recent years, in favour of a salaried model. It is often stated that young doctors no longer wish to take on the commitment of partnership, and instead are choosing salaried posts, and this may be true in current circumstances in Scotland. On the other hand, independent contractor general practice is flourishing in Denmark, where prohibition of ‘sale of goodwill’ does not exist as it does in the UK. A typical Danish GP has to find around £500,000 to join a practice and there is little evidence of lack of interest in taking on that commitment there. It may be significant that Scottish salaried GPs commonly take home larger earnings than partners (who have to pay both employee’s and employer’s National Insurance and receive no sickness benefits etc) and there is a strong argument for ensuring that contractors are better remunerated than salaried GPs for equivalent levels of clinical work. There are good arguments for extending partnership status to non-medical clinicians on a more widespread basis.

Resources should specifically be earmarked to support the retention and recruitment of substantial numbers of extra GPs. Initial urgent attention should be paid to retention – few GPs now remain in the profession beyond age 60 and many retire in their mid-50s - this represents the loss of an invaluable NHS resource. Over one third of Scottish GPs are

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1 Data to support these statements can be made available on request.
aged over 50 years\textsuperscript{ii} so there is a substantial risk that the decline in GP numbers will accelerate, making the profession even more unattractive to medical students (who may as a result have less exposure to general practice because of loss of tutors) and young doctors in the short-to-medium term as the service becomes even more overstretched. Mechanisms to promote retention could include enhanced pension benefits, reduced regulatory burden (eg annual appraisal requirements), support for teaching and flexible working patterns.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

As delineated above, the main barrier is undoubtedly the declining number of GPs and (to the average medical student) the increasingly unattractive nature of general practice work. The profession is demoralised. The recommendations made in the Wass report would go a long way to overcoming these barriers, as well as the incentives mentioned above to encourage entry into GP partnerships and to retain older GPs.

One of the barriers to national policy support for the independent contractor model is that contractors make decisions about what proportion of practice income they spend on patient care and what proportion they take as earnings. There is no doubt that there has been abuse of this system, and some practices (particularly some single handed practices in deprived areas) have very highly remunerated GPs (albeit at lower levels than the incomes of many hospital consultants) in the context of poor service to patients. The solution to this is to ensure first that GP superannuable earnings are completely transparent to the public and second that measures are put in place to ensure that excessive personal remuneration is penalised.

The current GP contract, implemented in April 2018, is also a barrier to delivering a sustainable primary care system. This contract was endorsed by only 28% of the Scottish GP workforce and it has already had a number of negative effects. Its adoption of a remuneration model which favours affluent central belt practices and relatively disadvantages the most deprived, and almost all rural, practices is particularly problematic. My recent submission to the Public Petitions Committee goes into more detail about this issue\textsuperscript{iii}. Furthermore many of the promised benefits of the new contract (eg community links workers, vaccination teams etc) cannot be realised in rural areas because of logistical issues and lack of economies of scale, causing further relative disadvantage to rural practices compared with those in urban areas. These issues have led to despondency among many of my rural GP colleagues. An additional negative consequence of the contract (in my view) is the creation of the idea of the future GP as an “expert medical generalist.” While this sounds laudable, it is likely to result in the profession becoming even more unpopular among young doctors because it will inevitably lead to a near-exclusive focus on older patients with multi-morbidity rather than the full range of medical problems across the lifespan. These encounters provide the foundation of personal continuity of care, and the joy of a general practice career.

Professional specialisation can cause particular difficulties in remote and rural areas. In isolated communities, rural generalists offer the most efficient and cost-efficient service. Until the 1980s, ‘Triple Duties Nurses’ provided midwifery, district nursing and health visiting services to many remote communities in Scotland. Once the potential for working in


\textsuperscript{iii}https://www.parliament.scot/S5_PublicPetitionsCommittee/Submissions%202018/PE1698_D_Professor_Wils on.pdf
this role disappeared, many of these communities lost local access to nursing professionals completely. There may be a case for opening a dialogue with the Nursing and Midwifery Council on this issue.

3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

*Multi-disciplinary teams.*

The replacement of functions previously delivered by GPs in favour of other professionals has been poorly evaluated, if at all. Difficulties in GP recruitment have necessitated these approaches and evaluation has rarely been seen as a priority. Compounding these operational difficulties is the poor state of primary care administrative data gathering and analysis. There is the potential, using routine data, to evaluate a number of important direct and proxy outcomes relating to different approaches to multi-disciplinary work, but this would require commitment to a greatly improved primary care intelligence capacity.

Use of primary care data in the NHS in Scotland has been severely handicapped by the near-complete failure of the costly SPIRE primary care data gathering system to generate any useful information. It is time it was abandoned in favour of a functional system such as ESCRO which my colleagues and I have been able to use to gather detailed information from a large representative sample of Scottish practices. The question of whether practices or Health Boards are data controllers also needs to be resolved. In order to ensure that evaluation data are of sufficient quality, it is essential that practice staffing is comprehensively characterised and data are entered into GP systems in such a way that clinicians can be identified and associated with individual consultations. Once that is achieved, it will be possible to assess personal continuity of care, consultation rates, diagnostic codes associated with individual team members, referrals to specialists etc. as well as to estimate the costs of providing care within different models and ultimately hard outcomes such as standardised mortality ratios.

*GP cluster working*

There is the potential, again with the benefit of improved access to routine data, to assess the extent to which coordinated approaches to care offered by GP clusters improves outcomes. Some work of this kind was conducted in relation to LHCCs and this type of approach could be replicated.

Naturally, the scope of cluster activity will determine likely outcomes for patients so it is difficult at this stage to suggest specific methodologies beyond the requirement for good quality data entry, comprehensive primary care records and good quality data linkage.

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**References**


6. Wass V. By choice — not by chance: supporting medical students towards future careers in general practice

