HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM DR HELENE IRVINE (recently retired from post as a Consultant in Public Health Medicine, NHSGG&C, post held 23 August 1998 to 1 August 2019).

Preamble: I have been studying general practice and how its disinvestment by government might be a key causal factor in the problems facing the NHS more widely since 2010. Throughout, I have been inspired and kept grounded by my many communications with GPs, most of whom I have found to be extremely hard-working, ethical and committed to their patients.

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.

Public views on the independent contractor model

The most important and revealing aspect of the H&SC report in my view was the following statement from pages 8 and 9 in the section on ‘Finance’, and the more detailed breakdown of the responses on pages 19 and 20.

“Survey questions were asked about the current model of funding GPs as independent contractors running their practices as small businesses. 79% indicated awareness of the model with 68% indicating it worked well or extremely well for them and 51% indicating it worked well or extremely well for the NHS. Panel members showed no interest in this aspect during their considerations.”

There are a few interesting points revealed by this summary:

- Most knew about the existence of the independent contractor model (79%).

- Only 68% reported that it worked well or extremely well for them, which is not good enough in my view, given the importance of the GP in detecting genuine disease/illness and protecting the patient from unnecessary investigation, over-diagnosis and over-treatment. This means that 32% (almost one third) did not believe the model worked well for them as patients. It would be worth carrying out another more detailed survey of their views to explore why they felt this way and in what ways they felt the independent contractor model did not work well for them.

- Almost half (49%) did not think the independent contractor model worked well or extremely well for the NHS which is uncannily perceptive of them given how little most of them actually know about the precise details of how the independent contractor model works and what problems are incurred by the use of this model for the wider NHS.

- Finally, the observation that ‘Panel members showed no interest in this aspect during their considerations’ is extremely interesting, though not surprising in my view.

These points interpreted together suggest to me that the independent contractor model is working best for GPs, given the evidence provided below about how determined GP partners have been to retain the model, but less good for patients and even less beneficial to the NHS as a whole, and
that the public don’t know very much about why it isn’t working as well as it should for them personally and for the NHS more widely. GPs and their union representatives (the SGPC within the BMA) have consistently kept the inner workings of the model, including the pensionable income data, very private since general practice was incorporated into the NHS as an independent contractor service in 1948. Successive governments have been obliged to cooperate with this level of confidentiality, which is unique within the NHS. All other aspects of the NHS are studied and the data generously published in ready-to-analyse format and routinely available on the ISD Scotland’s website, to its credit.

I believe that the public would be very interested in this component of the NHS if they actually knew more about how the independent contractor model works, including the fact that GP partners themselves decide on how much they work, when they work, how much to spend on service provision and how much they spend on their own income, and what are the associated problems of these freedoms. An obvious problem is that there is extremely wide variation in both performance and personal income of GPs, with no measurable relationship between what the GPs earn and the work they do, and the outcomes for their patients. Another less obvious problem with the independent contractor model is that it is very difficult for any government, via the health boards or HSCPs, to invest in general practice, which is a key part of primary care as it provides the necessary leadership and biomedical expertise, without risking leakage of that additional investment into personal incomes that do not correlate with workload, patient satisfaction or outcomes. If the government wants to preferentially invest in areas of social deprivation or rurality, and I believe it does, it becomes very difficult to do this confidently via the SAF/SWAF formulae without a risk of diverting of the additional investment as personal income. If the government chooses to alleviate the work loads of practice teams with support staff, as planned for the £230m accompanying the new GP Contract, as opposed to invest in the GMS budget, it risks seeing a small increase in overall output if less scrupulous GPs choose to transfer their workload to these support staff whilst maintaining their personal income. I fear that it is very difficult or impossible to regulate the independent contractor and might be even more difficult to regulate an independent contractor model that is combined with a salaried model, the latter funded by the government. The absence of financial accountability makes general practice an unappealing target for investment no matter how one looks at it.

Finally, to answer the question 1) “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”: After years of work and analyses of hundreds of datasets, my view is that we need to move to a salaried model of GP provision. Even if it is imposed on the GPs. All the facts point in this direction and a summary of the facts is attached in the appendix 1. These facts were recently summarised by myself and shared with the Royal College of General Practitioners (Scotland) for a Round Table discussion held on 31 July 2019 that included representatives of the Deep End GPs, the BMA, the RCGP and the civil service. In my view, after 26 years in public health in Scotland, 21 years of which were at consultant level at the largest health board in Scotland, employing GPs on a salaried payscale and investing in the service thereafter is the single most important thing the Scottish Government could do to turn around the NHS as a whole, so important is the role of the GP as gatekeeper to the rest of the service. This would also enable additional investment to areas of need without risk that the additional money is entirely or largely lost as personal income. This direction of travel would not be without its challenges as there would be a need for a large improvement in the quality of management of both GPs and hospital consultants for this to work.
Other aspects of public opinion

Apart from this insight on the independent contractor model, the Health and Sport Committee’s report on the public panels provides very useful insights about what the public, including those who regularly become patients, want to see in the way of primary care services. From my perspective as a consultant in public health who has studied the NHS in Scotland since 2010 from a health services planning perspective and why the NHS is struggling, I was very interested and pleased to hear that the public values continuity of primary care (quoted from Wensing et al 1998 in the Report) because in my view the loss of continuity that has characterised primary care over the past 20 years is one major reason that the overall NHS service is becoming expensive and wasteful. As the service becomes more fragmented and offered by a greater range of primary healthcare professionals, there is an increasing opportunity for unnecessary investigation, over-diagnosis and over-treatment in the worried well and increasing likelihood of missing real illness in the socially deprived. In my view, less is more. We need a smaller number of generalists with biomedical expertise who get to know their patients and their families rather than a very large multidisciplinary team who offer a fragmented service and seldom see the same patient twice.

Not surprisingly, the public panel reports that, amongst other features, the public want greater access outwith normal 9-5 working hours and a greater emphasis on prevention including more health checks. As a service provider, NHS Scotland has to remain mindful of the limited return on investment that is accrued when extending access hours and providing screening programmes. I comment briefly on these two demands below:

Extending access hours

How many people regularly need to see their GP before 8 am or after 6 pm given the existence of Primary care OOH services and A&E departments, which also require to be funded? Do we really need to extend the opening hours of daytime primary care services, and if so, would a modest extension for one or two days per week be sufficient? The work involved with answering these questions definitively is essential before we go ahead and insist that all health centres stay open for extended hours, including the most expensive component which is the GP component of that service, particularly when GP numbers have stayed flat these past 10 years in the face of rising demand for a GP consultation. The recruitment and retention problem in general practice is well known and has to be considered in all of this given that one thing mentioned in the review of published evidence referred to in the H&SC report (Wensing et al 1998) is that the public value competence/accuracy in their healthcare professional. Humaneness is also a valued quality but the bottom line must be that your doctor knows what he/she is talking about and diagnoses your problem correctly and/or refers you appropriately.

Health Checks

How much does it cost to screen all well people for many conditions in a universal health check, how many real illnesses and diseases will this pick up and at what cost per disease identified, and how many false positives will this pick up that result in people believing they have a disease that they don’t actually have? How disappointed will they be when a screening health check misses real pathology (false negative) which is also an evitable feature of screening/health checks. Health checks are popular with the public and are great for the individual when they pick up something important but are rarely 100% sensitive and specific. The decision to go ahead with the introduction of such health checks is one for experts who know the maths and not just a matter of public opinion.

Furthermore, the best way to improve public health is by ensuring that people have access to meaningful employment with the minimum of a living wage combined with public health protective
policies (e.g. ban on smoking public places) combined with an environment conducive to health that promotes exercise and being outside for part of every day (e.g. public parks, walkways, bicycle paths, street lighting, public sports facilities, etc). It would be an error of judgement to over-spend on health checks if this compromises the budget for communal/structural investments in health promoting infrastructure.

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

There are multiple barriers to delivering a sustainable primary care system, many of which are related to the GP part of the service, introduced in 1948 as an independent contractor. That is why sorting out this key aspect of the NHS has proved, over a period of decades, to be so difficult.

These include:

1) A general reluctance in the profession of general practice to examine and accept the results of analysis of routinely available datasets and evidence, unless it suits any pre-existing bias. My examination of general practice has identified multiple widely accepted myths that are diametrically opposite to the reality demonstrated by the evidence and data, most of which is readily available to anyone with a computer and internet access.

2) The dominance of the independent contractor model within a critical part of the NHS (general practice) which all four countries of the UK have found to be a barrier to improving the functionality of a key component of the service: the GP as gatekeeper, key provider of biomedical expertise in the community and mitigator of health inequalities.

3) The extraordinary loyalty to the independent contractor model displayed by so many people, including GP partners but also people peripheral to the work of actually being a GP but who are otherwise linked to this profession or have an interest in promoting the status quo. These include many people who believe that any other model would not match the efficiency of the independent contractor but who fail to provide evidence for this and who fail to examine the evidence for the failings of the independent contractor model.

4) The attitude of the many of the GPs themselves toward the independent contractor model which is at times naive in that they fail to grasp how exploitable it is by some of their GP colleagues and how debatable is the value in allowing GPs to retain the right to decide how much they work and how much they earn from a fixed financial allocation that is funded by the taxpayer, and retain confidentiality around all aspects of their working time, activity and remuneration.

5) The tactics used by the BMA’s SGPC which is to prioritise the optimisation of terms and conditions for GPs while insisting on an excessive level of secrecy in its negotiations with the government, and indeed with the GPs themselves. In addition, the BMA’s determination to maintain the high level of ignorance on the part of the public about what goes on in the profession, regardless of the behaviour of a minority of its GP members who chose to provide a minimalist service while maximising personal income. A key feature of the independent contractor is the freedom to confidentially determine a practice’s own income, and therefore the personal incomes of the partners who own the practice as a business interest.

6) The inadequacy of the government response to the above which has been to simply starve the GMS budget of resources since 2006, presumably with a hope that they can bring the independent contractors to heel and force them to accept a salaried model. This has been accompanied by multiple efforts to reduce the NHS’ dependency on GPs including by removing from them key clinical responsibilities such as ‘child and maternal health’ and centralising vaccination which is entirely counter-intuitive given that uptake is bound to fall for some groups if they have to travel further then their usual GP practice. Some of the problems with the
government’s response, in the form of the new GP Contract and related initiatives, to the challenge posed by the independent contractor are highlighted in my response to the Public Petitions Committee Hearing held on 9 May 2019 (PE 1698) (an abbreviated version of which is shown in appendix 2). Greater effort should have been made by the government to use existing datasets to prove to GPs and their leaders that the current model is failing.

7) The attitude toward general practitioners and inadequacy of managerial skills on the part of so many health board managers which is manifest in the way some health boards have managed the primary care out of hours service (e.g. NHS GG&C). One of the complications of allowing GPs to opt out of OOH responsibilities in the 2004 Contract was the fact that this commitment fell to health boards. There is considerable variation in how boards discharge this responsibility. However, in the largest board in Scotland, where most of the social deprivation is concentrated, the management and remuneration of sessional GPs for these services (primary care emergency centres and home visits) have resulted in a gradual reduction in functioning sites and what the GPs describe as unacceptable working conditions. This inevitably results in a further shift of OOH primary care workload to already oversubscribed A&E departments. The risk of a preventable emergency admission rises as a result and our dependency on secondary care increases rather than decreases as required by many policy documents.

8) The unwillingness, until recently, of the Royal Colleges of GPs (UK and Scotland) to express opinions about aspects of general practice that are deemed outwith their remit (the funding of general practice overall, the funding of GP practices, terms and conditions, what are acceptable levels of profit/personal income, etc.) The academic colleges have been advised to stick to issues related to ‘training and standards’, including by the BMA, even while the profession faces an increasing crisis. This needs to change as RCGP (Scotland) has major insight to bring to any discussion of a way forward to solve the most recalcitrant problem holding back the NHS.

9) The historical focus of the Deep End Group of GPs to highlight the disadvantages facing the socially deprived and the GPs that look after them as an argument for demanding more resource for Deep End practices, whilst ignoring the fact that income maximisation/profiteering has been shown to be maximal in deprived practices in that part of Scotland, namely GG&C, where most of the Deep End practices reside. This steadfast focus, and the fact that the Deep End movement has become a de facto voice of GPs in Scotland, has helped to divide the profession with the result that rural GP practices, affluent/elderly practices, and urban deprived practices vie with each other for falling resource instead of working together to devise a fairer system that the government will feel able to invest in, that will give better outcomes for all patients regardless of where they live, and that has a better chance of reducing inequalities in health.

10) The unwillingness of many public health professionals to study, expose and take issue with the problems in general practice and the role these problems are having in compromising the functionality of the rest of the NHS. My own profession of public health doctors are all too well aware of the crucial role the GP plays in the NHS as a whole and in public health terms and yet has remained conspicuously quiet as the GMS budget has been deflated in real terms and as a percentage of total NHS expenditure. In some cases this may be because they were, or still are GPs and would prefer to retain the status quo of independent contractor and the secrecy that surrounds how this model works. In other cases, it is probably due to the direction they receive from their managers and board level chief executives.

11) The political correctness involved with insisting that any discussion of general practice be immediately converted to a discussion of primary care. Primary care involves a wide range of other healthcare professionals, who have their own interests and agenda, and support staff. Insisting that any attempt to solve the problems in general practice be expanded to involve an attempt to solve the problems in primary care means we have never been allowed to have an
honest and fruitful discussion of the problems within the general practice component, including problems associated with the independent contractor. This debate is long overdue.

12) The ignorance on the part of the general public about the intricacies of the current system used to fund general practice as a whole, fund the practices individually, decide take home pay, and the many freedoms associated with the independent contractor model, including when they work. This explains why the public showed no interest in the public panels. This state of ignorance did not arise by chance but is the end result of an unofficial agreement between GPs, the BMA and the government to refrain from openly discussing sensitive aspects of the way the profession operates, including how it is paid.

The single most important barriers associated with the independent contractor model are the lack of financial accountability associated with it, the lack of control policy makers have over what GPs do, when and where they do it, and how much they are paid to do the work they do in terms of pensionable/personal income. There is an overwhelming need to invest more in deprived urban areas and ensure there are viable high quality services in rural areas and yet any initiative aimed at investing more in those areas risks being lost as personal profit as long as the GP can decide how many hours they work and how much they pay themselves to do the work they do.

Combining the independent contractor model with a salaried model using a ‘mixed economy’ is not the answer, and has failed this past decade despite a steep rise in numbers of salaried GPs, because the control of the falling resources still lies largely in the hands of the independent contractors/partners/GP principals. Investing more in the GMS budget at this stage is likely to result in a substantial rise in personal income given that average pensionable/personal income has dropped these past 10 years for most GPs; many and perhaps most GPs will feel entitled to divert any additional investment to their own personal incomes. Some of that investment might go to fund more salaried posts but may be offset by a reduction in working time of the partners to alleviate rising pressure. Directly funding GP salaried posts to be bestowed on deprived and rural practices by health boards and HSCPs could easily be squandered by less than scrupulous partners who simply pass the work on to these staff and work less for the same profit. The same can be said for the additional investment the government is currently making for support staff in primary care. Capping the independent contractor personal income is not the solution because:

A. income maximising practices tend to be poorly performing practices and they are not worthy of such income caps;
B. capping income will not ensure that personal income correlates with performance of a practice. At the moment there is considerable evidence that performance is inversely related to personal pay as it is very difficult to make large profits in general practice while offering a high quality services. This will not improve with the introduction of an income cap.
C. it may have a perverse outcome in that some GPs may feel tempted to cut their expenditures still further to reach the cap.

The nature of the independent contractor, that is the freedom to decide one’s working hours and one’s earnings, is that these negative consequences are all possible. Although blatant profiteering affects a very small minority of practices, the overall impact of a large investment, regardless of how it is organised/distributed, is a smaller than expected net increase in output.
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?**

Monitoring and evaluating the effectiveness of MDTs and GP cluster working will be extremely challenging as long as the current mixed economy of independent contractor, salaried GP employed by the partners, and a handful of directly funded posts (Pioneer GP scheme, Links worker scheme, SHIP scheme, etc) continues to prevail.

Governments will be wary of investing substantially either in the GMS budget or in the directly funded posts, via health boards and HSCPs, for the reasons described above, that this investment does not necessarily translate into more or better output in terms of workload or outcomes. Effective cluster working, between effective teams made up of GPs earning modest incomes whilst offering high quality services and single handed GPs who are choosing to maximise personal income whilst minimising the quality of the service offering, is unlikely to materialise.

For all the reasons cited above, a salaried model is long overdue and would be much easier to monitor and evaluate because all the data, including that revealing imperfections and poor performance, would be owned by the employer. Current plans to obtain data from the independent contractor are likely to result in disappointing data returns for a number of reasons, including the power of the BMA which is skilled at negotiating downgraded data return parameters, in terms of both quality and quantity, by their GP members.

Regardless of the system of funding and remuneration, the following would be useful parameters:

1) The number of GPs (headcount and WTE) in the practice with pressure brought to bear to eliminate single handed GPs on the grounds that they are the least financial accountable, are most likely to be practicing income maximisation, and are incapable of offering a service that approaches one offering ‘continuity’.

2) The average pensionable income per practice per 1,000 patients as a rough indicator of profits.

3) Vaccination uptake rates for the practice. Since vaccination uptake is one of the crown jewels described by Professor Sir Lewis Ritchie in the Public Petitions Committee hearing (PE 1698).

4) Screening uptake rates. I am not a fan of universal screening for reasons I have already shared with the H&SC, unless the screening tests are highly sensitive and specific, because it is an expensive way of improving the public health and creates false positives and fails to detect genuine disease via false negatives. However, as long as screening programmes are advocated by the SG and the health boards, we need to ensure that practices promote screening and that we are not paying large sums to GPs who don’t advocate such approaches.

5) Use of unscheduled care including Primary care OOH services, A&E, and emergency inpatient admission by the patients in the practice. I believe that, once they are adequately funded, very good practices will tend to have low usage of such unscheduled care.

6) Prescribing rates for anxiolytics such as benzodiazepines, opiate replacements, pain relief such as gabapentin, etc. This is more tricky because practices which accept very vulnerable patients may have high percentages of such patients.

7) Percentage of occupied emergency bed days for the 75+ age group that are in a GP led bed in those parts of Scotland that have such beds (most health boards have these beds with a notable exception being NHS GG&C).

NB The deprivation score of the practice is important to consider when evaluating 3) to 6). Recent communication with ISD Scotland suggests that funding and manpower data will not be available
by SIMD score or by urban/rural classification. It is extremely important that we analyse this data against both deprivation and degree of rurality.

NB We need to remain aware that some practices take measures to reject vulnerable patients who bring 'undesirable statistics' with them. As such, evaluation and monitoring of teams requires considerable insider knowledge of these practices, including their attitude to taking on vulnerable patients, including patients who have complex multi-morbidity, are heavy users of unscheduled care or bring with them high prescribing rates.

Finally, I conclude by adding that any over-haul of the funding of general practice within primary care needs to be accompanied by a large improvement in the quality of management within health boards and HSCPs. Some thought also needs to be given to how we try and retain the many positive aspects of the independent contractor, which include the efficiency of the running of these small businesses and the hard work most GP partners put in to the average day of work, whilst ensuring that GP performance is rewarded fairly and that some kind of relationship develops between pay and performance.

It would also need to be accompanied by a thorough review and over-haul of hospital consultants’ terms and conditions. The latter should include a comprehensive study of what they actually do, when they do it, how much time are they away on study leave or in private practice, for how many sessions are they paid versus how many they actually work, how much additional income do they earn in the private sector, how much additional income do they earn from the NHS clearing waiting lists at a higher wage, etc. Some of us suspect that the productivity of hospital consultant work could be vastly increased if the management of hospital consultants was of a higher standard and consultants spent more time on the ward and less time at their private clinics and on academic leave. This whole area requires rigorous scrutiny.
Appendix 1

Key facts sheet – submitted by Dr Helene Irvine, CPHM, NHSGG&C, to Round Table Discussion held by RCGP Scotland, at their HQ, Queen Street, Edinburgh, held on 31 July 2019.

Fact: Declining real terms expenditure on general practice: The percentage of total NHS expenditure in Scotland spent on general practice hovered at about 8% prior to the 2004 Contract. It rose to 9% in 2005/6 following its introduction. The four UK governments were directed by England’s DoH to reduce that percentage on the grounds that they had been too generous to GPs (that they were ‘paying GPs too much to do things they had already been doing’). Ever since the beginning of the reversal, the percentage has fallen annually and the most recent calculation from ISD cost tables suggests that it is now at a record low of 6.83% for 2017/18 (Fig 1). General practice is the only major category of health care that has been subject to a real terms decline in funding (Fig 2). This is perhaps the most important fact in the summary sheet because it provides the context for all the other issues. As the available funding drops to very low levels, it becomes ever more difficult for rural and deprived urban practices to cover for the rising additional costs of providing services in more remote areas or to patients with multi-morbidity and unmet need, even with their excess cost adjustments and morbidity/life circumstances adjustments, respectively. The GPs serving the urban affluent elderly have joined the GPs serving the rural and urban poor, in terms of finding it difficult to meet the high expectations and needs of that demographic, with the diminishing funding. Unhelpful divisions develop within the profession, which becomes protectionist and inward looking, with many GPs assuming that the GPs serving a different demographic ‘have it easy’. In fact, few if any GPs have it easy, regardless of where they work.

Fact: 10 Fold excess in funding for non medical support staff vs GP global sum budget: The Scottish Government is promising to spend £230m on support staff in primary care compared to the £23m invested in the New Contract, which is a 10 fold excess. Furthermore, it is reasonable to assume that claw-back of substantial fractions of the £23m tied up in the form of IEPPs will occur when resources become constrained. This suggests that the SG hoped that winning the vote for the new GP Contract would be cost-neutral. Source: Multiple sources including SG documents.

Fact: Falling trends in crude rate provision of GP partners by headcount and WTE: Over the time period of the decline in GP funding, crude rate provision of GPs (all grades combined) has fallen only slightly for Scotland as a whole. However, within that relatively stable provision, crude rate provision of GP partners has fallen substantially and been accompanied by a commensurate increase in crude rate provision of salaried GPs (Fig 3). The partner:salaried ratio has fallen from almost 11 to 3.5 over the 12 year study period. Furthermore, the trends in crude rate provisions of all GPs combined vary considerably across Scotland with clear evidence of a long term decline in many rural council areas (including Highland and the island health boards, Fig 4) with recently rising provision in many urban or semi-urban councils (including East Lothian, Edinburgh, East Renfrewshire, Perth and Kinross, Fig 5). Following the introduction of the new GP Contract in 2018, several cross-party MSPs claim to have received anecdotal reports of GPs leaving rural practices to move to urban practices because of perceived financial vulnerability linked to their dependency on large IEPPs. Crude rate of GP partner provision is declining in every council in Scotland and those councils with the steepest declines tend to be remote, rural or the in North East (Fig 6).

Fact: Higher, not lower, provision of GP partners in deprived areas: In terms of crude per capita provision, there are more GP partners, and fewer trainees, in deprived HSCP areas of GG&C, than in affluent HSCP areas of GG&C. East Dunbartonshire, which is the most affluent HSCP in Scotland, has one of the lowest provision of partners and the highest provision of trainees in Scotland (Figs 8
and 9). The low rate of provision of GP partners in East Dun reflects the smaller per head global funding and the high rate of trainee provision reflects the popularity of these practices for training. This pattern of provision in East Dun provides the ideal conditions for a high referral rate for both emergency and elective work for the affluent, particularly when so many hospitals are within short travelling distances. Analysis of routine collected SMR01 data demonstrates that both elective and emergency activity is higher than expected in East Dun and that the excess is higher than in any other HSCP in GG&C (Fig 10). The implication of this observation is that we need more GP partners in affluent areas, to control over-diagnosis and over-treatment in the worried well, and not just to address unmet need in deprived areas. Source: ISD Scotland routinely published GP workforce head count data. Source: Analysis of SMR01 activity as part of NHS GG&C CSR.

Fact: Deprived practices attract substantially more funding per head than do affluent practices in urban areas: Both total funding and global sum funding per head are substantially higher in deprived practices than affluent practices in both GG&C and Lothian. Most of the DE practices are in these two board areas. Therefore, inverse care law funding does not exist in the two largest urban board areas where the poorest patients are concentrated (Fig 11). Inverse care law funding at a national level is modest and occurs because of the high unit costs of supply in more remote parts of Highland and the island health boards where many elderly affluent Scots choose to retire (Fig 12). Source: ISD Scotland analysis provided by Ian Morton.

Fact: There is a statistically significant association between social deprivation and personal/pensionable income: Average Pensionable income per headcount also rises with rising deprivation and the relationship, when adjusted for size of the practice and number of partners, is statistically significant. Those earning more than £150,000 per annum are almost exclusively in the deprived half of GG&C (Fig 13) and are disproportionately likely to be single handed practices. Reliance on a single handed partner provision is more likely in deprived areas than in affluent areas.

Source: GG&C GP Pensionable income analysis carried out by H Irvine. Given comments made by the SGPC Chair during TAGRA meetings about the reluctance of government to fund deprived practices on the grounds that they were likely to simply take the additional funding as profit, this issue must be considered to be at the heart of the reason successive governments have been unprepared to increase funding to general practice generally and increase the steepness against deprivation of the funding formula specifically. If true, this provides an overwhelming reason to regulate the independent contractor, to free up the government to enable it to invest far more in general practice across the board. This would defuse the tensions created by a weighted formula that divides up an inadequate sum.

Fact: Substantial support amongst GPs for retaining the independent contractor: For many years that BMA has insisted that about 80% of partners want to retain the independent contractor. It would be worth exposing the data source for this quote. Source: The BMA. GP opinion on the ground suggests that they are now less likely to vote in favour of phase 2 because of their unwillingness to have their incomes determined by a salaried pay scale. Disaffection in some LMCs with the shortfall in funding required to honour the MOUs may accelerate the anti-phase 2 sentiments.

Fact: Legitimate aim of government to regulate general practice: Governments and their extensions (health boards/HSCPs) would like to minimise variation in practice and income amongst GPs, increase financial accountability of GPs, and gain greater control of GPs in terms of when and where they work, and what they do. Although there have been recent reassurances to the contrary, they probably want to replace the independent contractor model with a salaried model employed by HSCPs. Source: Multiple sources in conversation with health board and HSCP management, civil servants and BMA representatives involved in the negotiation for the new Contract.
Fact: The challenge involved with managing GPs: Managing GPs is a very challenging task that is best done by a very skilled manager who understands how to foster a mutually productive working relationship between them. The health boards have not proven themselves in this regard when it comes to managing either hospital consultants or 2c practices. Although there are exceptions, it is likely that only a very experienced and skilled GP can manage another GP and this is most likely to succeed when there is mutual respect and trust between them. Source: MBA online teaching materials. Various BMJ articles. Printed media articles. Confidential data on incomes and job plans obtained from the Financial Improvement Programme at NHSGG&C. Comparative cost data for 2c practices vs 17j contracts. The Sturrock Report on bullying in NHS Highland.

Fact: Rural and remote practices have legitimate concerns about the new Contract: One of the terms of the new GP Contract is that the IEPP component of funding, which now dominates the funding of rural practices, particularly in NHS Highland and the three island boards, will be subject to review by the relevant HSCPs. Despite reassurances that this component of their funding is 'safe', GPs believe that this money will be clawed back unless the practices can provide the evidence to defend that expenditure. All available evidence, including that presented by the PPC Hearing on Medical Practice in Rural Communities, suggests that IEPP will be subject to claw-back. An analysis of the datafile released by the SG shows that the 7th and 8th most remote and rural octiles of the Scottish urban rural classification received virtually none of the £23m uplift and most of the £23m of IEPP protected funding (Fig 14). This requirement for a higher level of financial accountability that is concentrated in rural and remote practices is not being routinely required of practices with very small or no IEPP component to their funding, nor is it being applied to urban deprived practices in GG&C earning the highest pensionable incomes. Source: Analysis of SG file of allocations with the new SWAF. Review of the New GP Contract. Discussions with RGPAS representatives.

Fact: A case study of the most deprived practice in Scotland: The practice that had the highest percentage of patients from the most deprived 15% of SIMD areas in Scotland for 10 years (Keppoch in Possilpark) has depended for many years on an MPIG that makes up one quarter of their total funding. The new GP Contract did not award them any additional money from the £23m investment and their MPIG was replaced with a larger IEPP. This suggests that the demographics (younger patients) and activity rates (lower than expected) for that practice did not attract any more funding via the new SWAF and that they needed even more bailing out via protected funding. This background suggests that the MLC index of both the SAF and the new SWAF is inadequate to cover the financial needs of this practice bearing in mind the inadequate global sum overall and the fact that it has been falling in real terms since 2006. Many other deprived practices also received small or no uplifts from the £23m and are dependent on protected payments which affects the practices' ability to recruit support staff.

Fact: Where did the £23m additional funding actually go? According to a cross tabs analysis of additional monies per head made available by the new GP Contract (i.e. £23m), the highest additional funding was distributed to the most deprived practices in urban areas with less than 125,000 population and small accessible towns, and not to the main cities in Scotland (Table 1). This analysis supports observations made by many of the most deprived Deep End practices in Glasgow city that they received little or no additional funding, a key example being Keppoch Practice, and/or had their protection payments increased. Per head allocations of the additional £23m in new monies were slightly higher in the most affluent urban practices than in the most deprived urban practices which is where the rumour arose that affluent elderly practices in the central belt attracted the bulk of the new monies. This was probably the result of the fact that the age/sex index was substantially higher, and the MLC index only modestly higher, in the new SWAF, than with the previous formula (SAF). Most of
the urban city practices characterised by considerable social deprivation received minimal increases and some of the most deprived practices attracted no additional funding.

Fact: Falling voter participation and the implication for the representativeness of the BMA’s SGPC: The voter participation rate for the new GP Contract was less than 39% which means that less than 28% of GPs in Scotland supported its introduction (70% of those who voted, voted in favour, and this reflects the percentage who were ‘gainers’ in financial terms).

Fact: NHS Scotland is experiencing increasing insurmountable challenges that may well be linked to the disinvestment in general practice: Audit Scotland has published a series of reports year on year that suggest that NHS Scotland is facing serious existential challenges including demand significantly exceeding supply, resulting in a range of performance failures and financial overparity or overspends. A key performance failure is reflected in the rising use of A&E and emergency inpatient beds in many health boards and the falling four hour A&E waiting time performance in most health boards. In recent months, demand for AAU beds exceeds supply many fold. The fact that there is a stark difference in the percentage of emergency occupied bed days for the 65+ and 75+ spent in a GP led bed in the north east of Scotland compared to the GG&C where there are no community hospitals and no GP led beds suggest that a sizeable proportion of emergency inpatient occupied bed days could be averted in GG&C if the elderly could access a community bed led by a GP nearer to their home. Hypotheses: There is a relationship between the weakening state of general practice and the existential crisis facing NHS Scotland. There is an inverse relationship between capacity in GP-led community beds and dependency on acute hospital care for the elderly. Source: Audit Scotland; ISD Scotland.

Fact: The consultant:GP ratio has been rising steeply for the past 20 years, an indicator of an emphasis on specialist over generalist biomedical provision: Whether measured as a headcount or in WTEs, the consultant:GP ratio has been rising every year since data collection started. Historically, the ratio was less than unity in that there were more GPs than consultants but this reversed in 2007, probably as a result of a large investment in hospital consultant budgets following the 2004 Hospital Consultant Contract. In recent years, the ratio for Scotland is about 1.4 (Fig 15). The English and Scottish ratios are extremely similar over time which suggests that Scotland has been influenced by the DoH in England with respect to this strategic direction on workforce planning. Within Scotland, the ratio varies substantially by health board area; the highest ratios by far are seen in GG&C and Tayside, even after adjustment for incoming cross boundary flow, both health board areas of which are subject to reviews because of financial overparity (GG&C) or overspend (Tayside). Sources: NRAC published data; ISD Scotland workforce data.

Fact: Crude per capita rate of consultation rose over the period of PTI data collection for GPs and practice nurses combined: The PTI dataset provides evidence that demand for services rose in general practice settings over its lifetime (2003/4 to 2012/13) (Fig 16). Crude per capita rates of consultation with GPs flatlined but those with practice nurses rose substantially over the lifetime of the PTI dataset (Fig 17). The near static crude rate provision of all GPs combined by headcount (Fig 3 in main fact sheet) may be the explanation for the flat consultation rate with GPs. Source: PTI.

Fact: All but one quintile of practices experienced a statistically significant decline in real terms pensionable income: Trends in real terms gross (Fig 18) and pensionable (Fig 19) income per 1,000 patients over a 10 year study period from 2005/6 to 2014/15 demonstrate a gradient in GG&C, with the most deprived quintiles (Q4&5) occupying the highest funding positions and the most affluent quintiles (Q1&2) occupying the lowest funding positions. However, all but one quintile of practices (in particular decile 8 within quintile 4, not shown), experienced a statistically significant decline over that
study period. This suggests that the decline in real terms funding of general practice highlighted in Fig 2 of the main fact sheet was accompanied by a decline in real terms pensionable income for 90% of practices across Scotland, during which time crude GP consultation rate was flat and combined GP and practice nurse consultation rate rose. Source: PI Analysis in GG&C by H Irvine.

Fact: Crude per capita rate of provision of practice nurses has risen substantially and far more quickly than crude consultation rate by PNs: Workforce data suggests that the steep rise in practice nurse provision (Fig 20), recently supplemented by the specialist NP or ANP, which occurred during the flat-lining of GP provision, has been steeper than the rise in consultations with a practice nurse (Fig 19). Source: ISD Scotland workforce data and PTI data.

Fact: Data underpinning general practice is compromised in a number of ways: The PTI dataset was regarded as inadequately representing both deprived and rural practices and yet was used to model the SAF and its replacement (SWAF); this is regarded as a fundamental reason that these formulae do not adequately remunerate deprived practices for the additional cost of providing services to the deprived and rural practices with low consultation rates for the additional unit costs of supply. The PTI dataset was abolished before a suitable replacement could be found (eg SPIRE) which meant out-dated PTI data from 2012/3 was used to design the SWAF in 2017. As of the 2004 GP Contract, it was no longer a requirement for GP practices to submit WTE workforce returns, which meant that health care planners did not have the data they required for GP workforce planning. In contrast, WTE GP workforce data is available for this time period in E&W. The decision to abolish QOF might have been welcomed by many GP practices but does away with another routinely collected national dataset that underpins general practice.

Fact: The fall in GP funding and rise in hospital consultant and community health services funding in 2005/6 was associated with a rise in use of unscheduled care: Strong circumstantial evidence of a causal relationship is provided by the fact that use of unscheduled care, including A&E attendance (Fig 21) and emergency inpatient admission (Fig 22), rose after the clawback of GMS funding in 2005/6 (Fig 23). Source: SMR01, A&E datamart data, R100T cost data from ISD Scotland.

Fact: Fall in life expectancy in Scotland, in particular in females living in more rural Scotland: Life expectancy at birth appears to have suffered in females living in accessible small towns, other urban areas (less than 125,000 population) and remote small towns (Fig 24), less so for males (Fig 25). Although the cause will be multi-factorial, the reduction in GP provision cannot be assumed to be irrelevant. Source: NRS Scotland.
Figures

Fig 1: Percentage of total NHS expenditure in Scotland spent on general medical services, 2001/2 to 2017/18. Source: R100T cost data available on ISD Scotland website.

Fig 2: Real terms expenditure (£s) on general practice in Scotland, by year, 2001/2 to 2017/18. Source: ISD Scotland R100T data and 2017/18 GDP Deflators published by the UK government.
Fig 3: Crude rate provision of GPs, per 10,000 population, by headcount, by category, 2006-2018. Source: ISD Scotland.

Fig 4: Crude rate provision of GPs, per 10,000 pop’n, (all grades combined), by headcount, for selected council areas with the largest percentage decline between 2008 and 2018.
Fig 5: Crude rate provision of GPs, per 10,000 pop’n, (all grades combined), by headcount, for selected council areas with the largest percentage increase between 2008 and 2018.

Fig 6: Crude rate provision of GPs, per 10,000 pop’n, (GP Partners only), by headcount, for selected council areas with the largest percentage decline between 2008 and 2018.
Fig 7: Crude rate provision of GPs, per 10,000 pop’n, (Salaried GPs only), by headcount, for selected council areas with the highest rates by 2018.
Fig 8: Crude rate provision per 1,000 population of GP partners, by headcount, by council area in 2014. Source: ISD Scotland.

Fig 9: Crude rate GP Trainee provision per 1,000 pop'n, as a headcount, by local authority, 2014. Source: ISD and NRS websites.
Fig 10: Standardised admission ratio (all specialities, all types) by CHCP using Rest of Scotland as the standard population, 2010/11. Source: SMR01 data provided by J Gomez.

Fig 11: Per capita global sum (£s per head) by mainland urban health board and by SIMD decile, 2015/16. Data source: I Morton, ISD.
Fig 12: Per capita global sum (£s per head) by island health board and for Highland and Scotland by SIMD decile, 2015/16. Data source: I Morton, ISD.
Fig 13: Categorical analysis of GP partners by pensionable income grouping, based on average pensionable income per headcount, against GGC deprivation decile of the practice in 2014/15. Sources: Analysis of average pensionable income per headcount in GG&C.
Fig 14: Proportional contribution to 2018 SWAF allocation per patient by urban – rural classification: IEPP vs additional monies from the £23m uplift. Source: H. Irvine analysis of the excel dataset issued by the Scottish Government in December 2017.
Table 1: Per capita distribution of the £23m in new monies under the new GP Contract analysed by both SIMD vigintile and by urban rural octile. Source: H. Irvine analysis of the excel dataset issued by the Scottish Government.

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Table 2: Modal Urban/Rural category based on numbers of patients in each rural category, per practice.

<table>
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<tr>
<th>Variable Name</th>
<th>Definition</th>
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<tr>
<td>Urban 1 - Large Urban Areas</td>
<td>Large Urban Areas - Settlements of over 125,000 people.</td>
</tr>
<tr>
<td>Urban 2 - Other Urban Areas</td>
<td>Other Urban Areas - Settlements of 10,000 to 125,000 people.</td>
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<tr>
<td>Urban 3 - Accessible Small Towns</td>
<td>Accessible Small Towns - Settlements of between 3,000 and 10,000 people and within 30 minutes drive of a settlement of 10,000 or more.</td>
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<tr>
<td>Urban 4 - Remote Small Towns</td>
<td>Remote Small Towns - Settlements of between 3,000 and 10,000 people and with a drive time of between 30 and 60 minutes to a settlement of 10,000 or more.</td>
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<td>Urban 5 - Very Remote Small Towns</td>
<td>Very Remote Small Towns - Settlements of between 3,000 and 10,000 people and with a drive time of over 60 minutes to a settlement of 10,000 or more.</td>
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<tr>
<td>Urban 6 - Accessible Rural</td>
<td>Accessible Rural - Settlements of less than 3,000 people and within 30 minutes drive of a settlement of 10,000 or more.</td>
</tr>
<tr>
<td>Urban 7 - Remote Rural</td>
<td>Remote Rural - Settlements of less than 3,000 people and with a drive time of between 30 and 60 minutes to a settlement of 10,000 or more.</td>
</tr>
<tr>
<td>Urban 8 - Very Remote Rural</td>
<td>Very Remote Rural - Settlements of less than 3,000 people and with a drive time of over 60 minutes to a settlement of 10,000 or more.</td>
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Fig 15: Consultant:GP workforce ratio: Numbers of WTE HCHS medical consultant staff: Numbers of GP principals and salaried GPs assuming 8 sessions per WTE in 2009, 2013, and 2015, by year, for selected health boards, Scotland and England. Sources: ISD Scotland and NHS Digital workforce data.
Fig 16: Trend in absolute number of GMS consultations by GP and practice nurse combined across Scotland: Source: PTI dataset, ISD Scotland.
Fig 17: Consultation/contact rate per 1,000 population for GPs and for Practice Nurses separately, for the duration of the PTI data collection period 2003/4 to 2012/13.
Fig 18: Real terms Mean annual gross practice income per 1000 practice pop’n by GGC deprivation quintile, GG&C GPs, 2005/06 to 2014/15. Source: GG&C PIA by H Irvine.

Fig 19: Real terms Mean annual GP pensionable income per 1000 practice population by GGC deprivation quintile, GG&C GPs, 2005/06 to 2014/15. Source: GG&C Pensionable Income Analysis by H Irvine.
Fig 20: Crude rates per 100,000 population of practice nurses and nurse practitioner/advanced nurse practitioner combined across Scotland: Source: ISD workforce data and 2013 Primary Care Workforce Survey.

Fig 21: New A&E attendances, all types of sites, for Scotland, for all ages, using ISD(S)1 and A&E Datamart data. ISD Scotland.
Fig 22: Number of emergency admissions (all specs, all ages, all stays) at GG&C sites, 1995/6 - 2014/15. Source: SMR01 data from J Gomez.

Fig 23: Percentage of NHS expenditure on community health and general practice (right axis) vs the number of emergency admissions (left axis) in Scotland by year, 2001/2-2015/16. Source: ISD Scotland.
Fig 24: Life expectancy at birth, for females, by urban rural classification. Y axis truncated. Source: NRS Scotland.

Fig 25: Life expectancy at birth, for males, by urban rural classification. Y axis truncated. Source: NRS Scotland.
Appendix 2

Submission to the Hearing of the Public Petitions Committee on Medical Practice in Rural Communities held on 9 May 2019, by H Irvine, CPHM, NHS GG&C

The views expressed below are not necessarily shared by either board members or managers of NHS GG&C. These need to be read in conjunction with the original petition from rural GPs and the transcript of the actual hearing, which is available at: http://www.parliament.scot/parliamentarybusiness/report.aspx?r=12095

Summary of my evidence submitted in response to the PPC Hearing 1698

• The selection of panel members was such that those present were not sufficiently qualified to answer all the questions satisfactorily. This problem is very complex as is the mathematical modelling used to design a funding formula. But that should not be used as an excuse for what is an unsatisfactory attempt to remodel a formula and reissue a GP Contract, and an even more unsatisfactory attempt to explain it.

• On balance, it would appear that the current and previous governments throughout the UK did not value general practice overall, based on historical trends that demonstrate long term and increasing underfunding. General practice has been singled out for sustained real terms disinvestment in all 4 countries of the UK and it is important to highlight this fact early in this summary because it largely explains why any new Contract and funding formula are likely to face major challenges; the sums being split up by the funding formula are far too small for the task, and falling in real terms. This means the most vulnerable patient groups, in terms of either geographic access or social deprivation, lose out the most.

• The fact that recent funding of general practice in Scotland, as a percentage of total NHS expenditure, peaked in 2006 and has been falling ever since, and that this period coincides with the SNP’s position as the political party in Government, suggests that SNP policy is to gradually reduce the NHS’ dependency on GPs. The fact that key responsibilities are being removed from either GPs or general practice settings also suggest that government policy is to diminish their role. The decision to stop collecting PTI data in 2014 before a valid replacement had been set up also suggest that general practice was not deemed to be an important part of the service. Recent plans by the SNP Government to invest £230m, which is 10 times the recent uplift associated with the new GP Contract, in non medical primary care staff, appear to consolidate their intentions to replace GPs with less qualified staff. Unfortunately, this strategy, examined in its entirety, has no evidence base to support it and has never been consulted on with the public or GPs. I believe this is a key causal factor in the NHS’ decreasing ability to cope with demand.

• With respect to rural and remote general practice, the SG and BMA agreed a strategy, in the absence of oversight from TAGRA, that would take the excess cost of supply adjustment out of the funding formula (hence the renaming of the formula as a ‘workload’ formula) and reassure the affected GPs that the difference between their new and historical allocations would be protected under the guise of a newly named funding component called the IEPP. The combination of the fact that the most remote and rural practices (categories 7 and 8 from the urban rural classification of 8 octiles) attracted negligible additional investment from the £23m uplift, at a time of rising workload, complexity, and expectations on the part of the public, and the fact that they were most affected by IEPP protected funding (see the Figure on Allocation and Protection per head shown in Submission PE1698_Q) suggests that the negotiators of the new Contract valued rural general practice the least and assumed they could make these substantial changes with neither oversight from TAGRA nor consultation with either rural GPs or the rural
communities they serve. By distributing the £23m to 70% of the GPs, they predicted they could secure 70% of the vote and they achieved that, albeit with such a low turnout that the validity of the entire exercise is questionable and the mandate of the BMA to represent GPs left in doubt. More importantly, they lost the trust of the rural GPs in the process.

- All the information available suggests that IEPP will be vulnerable to claw-back, particularly as available funding diminishes. This information includes the fact that the sum total of IEPP (£23,193,333.05) exactly equals, rather than roughly approximates as suggested by the negotiators and the Government, the sum total invested in the new Contract (£23,193,333.05); the fact that its predecessor (MPIG) was vulnerable to claw-back; and the fact that the excess cost of supply adjustment that is so critical in rural and remote practices, which makes up the majority of funding covered by IEPP, was deemed to be based on poor quality data. It is reasonable to expect that the government is going to want to claw back some of that £23m if they think it is inflated because of poor data. Recent attempts by the BMA or the government to dismiss the possibility that the IEPP would be vulnerable to claw-back are impossible to refute but all the evidence suggests that it was.

- A point that I suspect was less well understood by PPC members is that, historically, many deprived urban practices were also dependent on MPIGs to survive, but for a very different reason: because the Morbidity and Life Circumstances Index (MLC adjustment for poverty and high rates of illness) was inadequate. Many of these deprived practices have seen their MPIG replaced with a larger IEPP in this new contract. This explains why the most deprived urban practices were also very unhappy with the new SWAF allocations. This suggests that the government planned to introduce a new funding formula that, in a stroke, obliged urban deprived and rural/remote practices to demonstrate the need for their funding and therefore demonstrate compliance with a higher degree of financial accountability than practices serving middle and higher income patients in the central belt. Introducing a contract of this nature that is perhaps ‘too clever’ in the absence of adequate consultation was bound to get into trouble given that two vulnerable patient groups, the urban deprived and the remote/rural, are affected. Calls to increase funding to the GPs looking after the urban deprived have long been successfully ignored as can be verified by the Deep End Steering Group. On this occasion, the Scottish Government made a tactical error by also alienating the minority of GPs who are rural or remote. The latter were already leaving rural general practice for reasons that include the diminishing real terms global sum funding described in the third bullet point above in the face of high unit costs of supply and falling access to support staff. I believe that this tactical error on the part of Government will further compromise the rural communities who depend on these GPs.

- Falls in life expectancy in rural Scotland will be multifactorial in origin. However, given that GP partner numbers started to fall in rural Scotland in 2008/9, following the national claw-back of GP funding in 2006 mentioned in bullet point 3, and that life expectancy started to fall in 2010, the timing of the drop in life expectancy is in keeping with a role for the diminished access to a GP partner who knows the patient. It is naive to believe that we can disinvest in general practice across Scotland from 2006 onwards, rely increasingly on salaried GPs who are less likely to know their patients and less committed to ensuring the survival of the practice, and neglect the need to create real incentives to work in more remote and rural parts of Scotland where distances to hospitals can be very great; and see no untoward effects. The new Contract introduced in 2018 cannot be blamed for the downturn in life expectancy that started in 2010. However, it is reasonable to expect that it might exacerbate that downturn by accelerating the ongoing reduction in GP partner numbers by fuelling early retirement and migration to urban general practice, and discouraging recruitment.

- There is circumstantial evidence acquired from membership of TAGRA, discussions with negotiators, emails from senior managers and minutes of meetings that suggest that there was indeed a bias on the part of some of the key negotiators against trying to find a way to
The fact that the BMA has such a substantial role in influencing the design of a funding formula when it clearly will want to keep all members happy introduces a built-in bias to ensure a flat funding formula against deprivation. This probably explains the historical application of what the academics linked to the Deep End have described as Inverse Care Law Funding of general practice at a national level. In addition, the lack of financial accountability associated with the independent contractor and the evidence that income maximisation has been found to be concentrated in deprived areas are legitimate reasons why the government may not have been keen to invest more in areas of most need. The fact that a minimal fraction of the £23m went to remote and rural practices and that they bore the brunt of the IEPP allocations suggests that there was a determination to treat those practices differently and leave them behind in financial terms. As such I do not believe that the potential impact of the formula on urban deprived or rural/remote areas was not preconceived to some extent in the design of the formula or at the very least, in the way it was implemented, including the removal of the excess cost of supply adjustment from the formula.

- The new SWAF does make the funding formula steeper against deprivation as described in Submission PE1698_Q but the end result is that significant shifts in resources were directed to urban/rural categories 2 (other urban areas with population less than 125,000) and 3 (accessible small towns) rather than to large urban cities. The most deprived practices in terms of the percentage of patients from the 15% most deprived in Scotland are in the large urban cities. Most of the Deep End practices are in Glasgow and Edinburgh. Submission PE1698_Q should have shown the breakdown of the £23m in a two by two table with deprivation on one axis and urban rural classification on the other axis, given that the Chair of the PPC Hearing made it clear that she wanted to know precisely where the money went. This table shows clearly where most of the £23m was directed; the highest per capita awards went to the most deprived in urban areas with populations smaller than 125,000 and to accessible small towns.
- Having studied the excel file of target shares by practice, as determined by SAF and then by SWAF, broken down by component parts, distributed by the government itself it is not clear how the government can claim to have increased the value of the Contract by £46m. They claimed to have invested £23m in the Contract in their own written documents. Why claim at this late stage in a PPC hearing to have invested twice that sum when there is no evidence to substantiate that claim?
- An MSP at the hearing suggested that they have heard many accounts of GPs leaving rural to move to urban general practice. In the absence of interviewing GPs and asking them where they started off and where they are now working it is difficult to conclusively prove that there is migration of GPs from rural to urban practices. However, routinely collected headcount trend data of GPs by council area published by ISD Scotland can be analysed and this suggests that there is indeed a drop in rural rates of GP provision by headcount starting after the 2004 Contract that has accelerated since and a very recent steep rise in urban provision starting after 2013. The long term drop in GP crude rate per capita provision is quite marked in certain council areas including Highland, Dumfries and Galloway, Aberdeen City, Midlothian, W Isles and Shetland. The recent rise in provision is seen in Edinburgh, East Lothian, Borders, West Dunbartonshire, Dundee, Perth and Kinross, North Ayrshire and East Renfrewshire. These analyses also demonstrate that these recent rises in GP provision are largely made up of increases in salaried GPs. The fact that the RGPAS Chair himself recently moved from a Partnership post on the island of Arran to a salaried post in East Lothian is a case in point.
- Given the fact that the general practice/health centre infrastructure and their clinical staff are already in place it seems remarkable that policy makers would plan a wholesale shift for vaccination to centralised locations where staff are bound not to know the patient, ostensibly on the grounds that school aged vaccination is best carried out at school and that the complexity of
vaccination is rising. Citing the example of a modest rise in uptake of flu vaccination in school children in the Western Isles does not make the case for this strategy, which carries the risk of a fall in uptake, particularly in babies, preschoolers and the elderly, as cited by Ms Grant. Again, this suggests that Scottish Government policy is to reduce its dependency on GPs, including for protecting the ‘crown jewel of vaccination’. **There is doubt as to whether the Vaccination Transformation Strategy was adequately consulted on with GPs and the public who will have to travel longer distances to obtain routine vaccination and whether uptake of all vaccinations will be sufficiently improved or at least maintained to justify all the upheaval.** Reassurances from the panel came across as both a partial u-turn and shallow given that so many rural and remote practices will not be able to find the staff to carry out these vaccinations.

- Having sat through all the TAGRA meetings where the SAF Review was reported on by civil servants and the BMA negotiators, I can testify to the fact that this process was unsatisfactory throughout in terms of rigour and accountability. It came across as tokenistic oversight by a group of well meaning senior health board staff who were not given the full picture and who were too close to the end of their careers to put in the full effort required to grasp it all. Furthermore, **TAGRA’s oversight of the SAF Review was abruptly brought to an end in the last few minutes of the 25 August 2016 meeting** and there was no suggestion up to that point that the excess cost of supply adjustment would be entirely removed from the formula and effectively replaced with IEPP funding. The removal of TAGRA from the process and the decision to remove the excess cost of supply adjustment cannot be defended on the grounds that negotiators were about to start discussing and negotiating ‘GP pay issues’. **That is an old excuse that has been used by the BMA and government to impose an unnecessary and unhelpful degree of secrecy over the entire discussion that has not been in the interests of the NHS, the public, or the GPs.** The lack of openness on the part of the BMA with their own GPs goes some way to explaining the very low uptake (39%) for the vote for phase 1.

- As the gatekeeper to the entire NHS service, the GP has a particularly critical role, in my view the most important role, in ensuring that sick people get what they need and that the worried well do not consume more investigation and treatment than is warranted. Both of these tasks require highly trained and highly skilled staff who know the patient and cannot be done efficiently and cost effectively with a much larger team of less trained and less skilled staff that includes a smaller number of GPs, no matter how noble the intention. It is possible to have too many cooks in the kitchen; primary care becomes fragmented, expensive and unwieldy. **The fact that various datasets have been abandoned (PTI, QOF), and key data not collected (WTE workforce) provides additional evidence that the Scottish Government did not recognise the centrality of the general practice service within what they prefer to refer to as ‘Primary Care’.** Instead, they were focussed on what they perceived to be less desirable features including their inability to control the independent contractor model and the less than optimum degree of financial accountability, including the risk of personal income maximisation at the expense of good quality service provision. This focus has distracted them from the need to ensure that the service is strong, viable and regulated and that is not possible without good quality data. The government should have been resolved to strengthen the data prior to the commencement of the SAF Review and prior to the release of a new Contract instead of hoping that the victory of the phase 1 vote would provide the data they need after the fact. The consequences of this misjudgement have now come to light because they have been obliged to use outdated data that was known to poorly represent both the socially deprived and the rural/remote to develop a critical funding formula, thereby further alienating the GPs providing services to the socially deprived, and adding to the disaffected the rural/remote GPs.

- The story of Keppoch practice in Possilpark Health Centre makes clear that it is not just the rural and remote GPs who are feeling vulnerable because of an expanded IEPP.
component to their funding. The practice that held the worst position on the social deprivation league table for more than a decade relied for much of that time on an MPIG that made up a quarter of their total funding. Meanwhile, the health board had repeatedly threatened to withdraw that MPIG on the grounds that they could not afford to continue subsiding that practice. This provides very strong evidence that the 2004 SAF formula did not take sufficient cognisance of the cost of providing a good quality service to the poorest people in Scotland. The New Contract introduced in 2018 gave them not a penny more from the £23m uplift but did expand and rebrand their protected funding leaving them with an even larger IEPP. I have to question a formula and contract that gave no uplift to this practice but expanded their IEPP. I have studied this particular practice in detail, from all angles including their personal incomes, and in my view, you could not find a more committed group of moderately remunerated GPs who know their patients, and do their best to deliver what their patients need with overall funding levels that look inadequate when compared to most European countries.

The full submission has already been submitted to the Public Petitions Committee and is available on request.