Primary care crisis: fight for a better future

Britain should be proud of the NHS, and nurse it back to health

"If you had the hypothesis that the government was seeking to destroy the National Health Service...all the data that we're seeing are consistent with that hypothesis." (*Marmot)*

- *Primary care must be a publicly funded and NHS delivered service.*
- *Health expenditure is essential infrastructure investment; it contributes to better health and delivers a fourfold economic return. (WHO)*
- *Primary care is 'the most inclusive, equitable, cost effective and efficient approach to enhance people's physical and mental health'. (WHO)*

1. Why is primary care so important?

- Patients rely on a skilled, high quality, reliable, accessible general practice, as this is the main arm of the NHS patients contact (90% of patient contacts are with primary care).
- A year's worth of GP care per patient, costs less than two trips to A&E, (some estimates are £40 for GP visit and £250 plus for outpatient visit), so increasing General Practice's share of NHS spend, and therefore capacity to prevent, intervene early and treat illness, makes economic sense.
- Primary care is one of the four features highlighted as crucial in top performing health care systems, but the UK comes 9th of eleven high income countries for health care outcomes (Commonwealth Fund). It *''is a whole-ofsociety approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution, by focusing on peoples' needs, and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment." (WHO)*

2. Primary care crisis

Primary care is described by some as at breaking point, as is the rest of the NHS and social care, resulting in higher levels of mortality, illness, pain, and anxiety, with its attendant impact on people's daily lives, families, and livelihoods. However, this crisis was not inevitable, nor the consequence of the pandemic, but the result of successive political decisions, a government made crisis. So, different decisions can make primary care, and the rest of the NHS, a service that meets need, and that we can again be proud of. Other comparably wealthy countries, whatever their model of fundraising, tax and/or social insurance, just spend much more.

Patient satisfaction has plummeted as thirteen years of underfunding mean patients face potentially life-threatening waits at each stage, from delays and difficulties contacting GP practices, long waits for an appointment, talking to different clinicians for every contact, who know little about them, repeated telephone triage, frustration with e- consult and Patient Access, long waits for referrals to secondary care for diagnosis and treatment (Healthwatch and others).

- Funding for primary care has shrunk as a percentage of healthcare spend, 9%, and is well below the OECD average, 14%. Twelve years of underinvestment have eroded capacity, (staffing, equipment and premises), job satisfaction and morale, with demand now massively outstripping supply.
- Austerity's cuts to partner services e.g. social care, community nursing, hospital capacity, public health, dentistry and end of life care, has led to an increase in poverty, and more very ill patients living in the community, dependent on primary care, with fewer if any services for earlier intervention, additional support, or timely onward referral.
- These barriers to timely care, have undermined clinical standards, with lethal consequences. (Goyal)
- Creeping privatisation and hostile political and media comment has added to demoralisation, anxiety and despair for patients and staff.
- The combination of these factors has left staff feeling deskilled and anxious about being forced to offer a residual, 'firefighting' service, not the safe, high quality and personalised care, that led them to choose their professions, and for which they were trained.

This situation is set to accelerate thanks to the government's recent budget, the scrapping of manifesto targets to recruit 6000 extra GPs, the reintroduction of the cap in medical school places to near pre pandemic levels, even for students who deferred taking their place during the pandemic, continuing recruitment and retention issues for other primary care staff, Integrated Care Systems' (ICS) capped budgets, and the reduction in GP representation on ICS boards.

3. Crisis in detail

Impact on patients

- There are an estimated 500 deaths per week resulting from long A&E waits. (Full Facts)
- Over 7 million patients are waiting for surgery because of a decade of austerity and managed decline (Kings Fund).
- Standard consultation lengths are much shorter in the UK than in other high-income countries.
- Life saving continuity of care has been eroded and undervalued
- Austerity's negative impact on all the social determinants of health (income, work, housing, education, early years provision, and the environment) has increased preventable health inequalities, led to life expectancy stalling, and decreasing for women and 45–49-year-olds, particularly in the 10% most deprived areas in the Northeast.
- Patients with chronic conditions are overrepresented in disadvantaged populations; nearly a third of over 15's have two or more chronic conditions, and two thirds of over 65's across the OECD. (OECD 21)
- There are significant variations in provision, with fewer GP practices in remote areas, and/or those with higher proportions of disadvantaged or older people.
- The fate of NHS primary care dentistry, unobtainable in many areas, particularly rural and deprived ones, with nine out of ten dental practices not taking on new adult patients, should be a warning about what could happen to primary care.

Funding

The extent of the UK's chronic underinvestment on all aspects of healthcare compared with similar countries, is massively understated by politicians and the media.

- In every year from 2010-2019, the UK would have needed to spend an extra £73bn more to match Germany's spending per person (39% extra) or an extra £40bn (21% extra) per person to match France's, with only Spain. Portugal Italy and Greece in the EU 14 spending less per person than the UK. (Health Foundation, 2022). The UK spend per person was £3055, 14% less than the EU 14's £3655, from 2010 -2019. (Kings Fund)
- Inter-country comparisons: UK ranks 29th for number of doctors, 22nd for nurses/ 1000 population, 32nd for number of hospital beds , 12th for the percentage of GDP spent on health care, and 24th for life expectancy at 65 years (OECD). It had 7.2 MRI scanners per million population, compared with a 19.3 average for similar EU countries.
- Primary care is responsible for 90% of all patient contacts but yet it receives only 9% of NHS spend, lower than the average (14%)of comparable OECD countries, with Spain and Estonia spending 17% and Australia 18%.

Staffing

Shortages of GPs and nurses, and major difficulties with recruitment and retention, and staff leaving, (retiring early or working reduced hours), faster than they can be trained and recruited, have not been addressed. The cap on medical training places, withdrawal of adequate nurse training bursaries, attempts to substitute other roles for GPs and nurses, proposals to dilute medical training, and provisions in the Health and Care Act permitting the deregulation of health professions and their professional bodies, are eroding safe, evidence-based patient care.

- Primary care is still 6000 GPs short. The recruitment of other primary care staff, under the Additional Roles Reimbursement Scheme, whilst potentially adding valuable members to the team, is not a substitute for more GPs and nurses, and does not reduce the GP workload. These other roles cannot replace the latter's diagnostic

and treatment skills. Equally, digital and AI advances, important as they are for some administrative tasks, and diagnostic and treatment improvements, cannot safely or cost effectively replace the need for more GPs and nurses.

- Full time equivalent qualified GP numbers fell from 29,364 to 27,513 between 2015 and 2022.
- GP job satisfaction is lower in the UK than in international counterparts.
- GPs' main reasons for leaving, are retirement, stress/burnout, dissatisfaction with role or workplace, medico - legal worries and regulation. (RCGP)
- Non-medical staff's pay and conditions are often worse than for those working in similar jobs in hospital, further undermining recruitment and retention.

Workload

Workload has dramatically increased due to a growing and elderly population, austerity's negative impact on health outcomes, with higher levels of ill-health in the community, cuts to other services, the pandemic, and burgeoning bureaucracy.

- Despite this, English GPs now care for 15% more patients than in 2015, and primary care teams provided 370 million patient consultations in 2021, an 18.5% increase over 2019.

Cuts in other services have been dramatic, further decimating community health promotion and provision.

- Social care's largely privately run, fragmented service, is usually unable to adequately care for even the frailest and sickest, or deal with the Discharge to Assess scheme, whereby patient needs are only assessed after hospital discharge.
- Public Health should play a major role in health service planning, disease prevention and control, but had its grant reduced by 15% from 2013/4 to 2019/20.
- Community nursing services have seen a 48% reduction in district nurses, between 2009-2019 with claims that this poses a direct threat to patient safety and a 35% fall in school nurses.
- Two thirds of community palliative and end of life care is voluntary funded and insufficient to meet need.
- Dentistry is a largely a non- NHS service now, unavailable to many patients who are dependent on primary care for pain relief and antibiotics.

Centralised bureaucracy, administration, targets, inspection regimes, bidding rounds for small pots of money, and task shifting from hospitals to primary care, has increased significantly.

Corporate privatisation

Privatisation is a growing threat with a move away from GP partner led practices and the takeover of practices by big multinationals and US health companies, as occurred with the Operose /Centene takeover in London. Some of these companies and their subsidiaries have been fined in US courts for fraud, false claims, wage violations and healthcare related offences, yet they are able to win contracts here. (Violation tracker)

Private providers on Alternative Provider of Medical Services (APMS) contracts, are paid 14% or more per patient, than GP led NHS providers on General Medical Service (GMS) contracts, for no extra services, and often deliver lower patient satisfaction and poorer quality care. Personal Medical Service contracts, similar to GMSs are being phased out.

APMS's also risk fragmenting and destabilising local provision, poaching scarce GPs, and cherry-picking fitter patients. If disappointed with profit levels, private companies have terminated NHS contracts early, leaving localities to pick up the pieces. For all these reasons corporate involvement represents a very poor use of taxpayer funds.

4. Myths

- Increased spending on the NHS and primary care are unaffordable. Not the case. It is lack of health promotion, early intervention, and health care, leading to high levels of illness, and inability to work, that are unaffordable and damaging, for individuals and the economy (IPPR). Spending on healthcare is an investment resulting in a fourfold economic return. (WHO)

- Improved capacity in primary care will automatically reduce the need for expenditure on hospital care. No, there will need to be expanded capacity in primary care *and* acute care, because years of underfunding have undermined both.
- Continuity of care is a luxury incompatible with modern general practice. On the contrary, continuity of care is an essential component of safe healthcare, compatible with larger, multi- disciplinary teams, and improved access. Within large practices, continuity may be provided by named GP lead and supervised micro teams. Continuity of care, with a known doctor, facilitates timely diagnosis, reduces over-diagnosis and treatment, and the chance of 'missed' symptoms, increases patient compliance with treatment, and reduces mortality. It can also improve GP job satisfaction.
- IT, remote consultations, and telemedicine will make up for the shortage of GPs. It will not. As an aid, increasing the repertoire of responses and choice of contact, mutually decided by clinician and patient, digital modes can be a real advance. However, as an enforced cost saving substitute for physical examination and continuity of care, they will prove dangerous, with missed symptoms, delayed diagnoses, costlier, later treatment, patients forced to withdraw from an already depleted labour market, and escalate staff leaving, because of the additional clinical risks.
- The private sector can save the day, reducing the elective surgery backlog and increasing primary care capacity. This is a fallacy. The private sector does not have the capacity (8000 beds to the NHS's 150,000). Its staff are mainly NHS staff who can either do NHS *or* private work. Most private hospitals do not have the intensive care provision required in NHS hospitals that undertake surgery, and therefore must export 'errors' back to the NHS. The private sector may be in a position to help at the margin, which might be acceptable for the short term, if they were on NHS payment rates, the same rules governing transparency, and on a semi - requisitioned basis.

  Social care and dentistry are chilling examples of the failure of the private sector in healthcare, and where primary care and the rest of the NHS could soon end up if it, rather than the NHS continues to be prioritised as recipients of taxpayer funds. Objection to the way the private sector has been involved by government is not ideological but based on the track record of higher costs and less effective delivery and lack of transparency. Better value is obtained from long-term investment in NHS provision. In primary care, private providers are paid more (14% per patient), but do not increase capacity, drawing as they do on the same pool of GPs and nurses, and can only make profits by reducing the numbers, and/or experience of staff, and relying more on digital and remote contact.

5. KONP is calling for urgent action to:

- **Fix the crisis *AND* re-build primary care fit for the 21st century**, patient designed and focused, prioritising continuity of care (it saves lives), well resourced, central to the NHS, and embedded in communities. It will operate as local, **one -stop health and wellbeing hubs**, providing health promotion, preventive, medical and some outpatient services, in partnership with others, e.g. social care, hospitals, public health, community nursing, palliative care and the voluntary sector. Support, evaluate and extend promising existing initiatives.
- **Raise primary care funding to at least the OECD average (14%),** and raise NHS spend as a percentage of GDP, to the level of comparable countries, to redress staff, equipment and premises shortages. Healthy countries are economically healthy also. However, PFI and similar models must not be repeated as a means to achieve this.
- Target new funds and workforce incentives to disadvantaged/underserved areas, to reduce mortality and morbidity, reweight the Carr Hill funding formula and ARRS allocations more heavily for deprivation to align more closely with need.
- **Increase the workforce: fund enough doctors and nurses to keep the NHS safe** with rapid recruitment, training, returnees, and retention programme, e.g., attract and facilitate returnees/retirees on flexible terms, fund additional university and practice-based training places, reinstate adequate **nurse bursaries.** fix visa issues for overseas graduates and barriers to refugee health professionals and introduce NHS terms for administrative staff. Review workforce strategy annually.
- **Reduce the workload:** cut unnecessary work - fund Primary Care Networks and larger practices to expand support to others for back-office functions, e.g., HR, premises, improved IT for administrative tasks, end

unfunded task shifting by hospitals and others to primary care, and scrap current inspection arrangements (CQC and QoF). Cap patient list sizes, reintroduce personal lists, and prioritise continuity of care alongside improved access.

- **End waste and privatisation:** stop award of new private *Any Provider of Medical Services (APMS)* contracts, paid 14% more per patient than NHS *General Medical Service (GMS)* contracts, and phase out existing APMSs. Explore and support new NHS salaried practice models with PCN/ Federation/ICS held contracts, Employee Ownership Trusts (Somerset) and others.
- **Increase GP and patient representation** in Integrated Care Systems to ensure more patient centred primary care.
- Raise Investment in **community nursing, social care, public health, hospital, dentistry, and palliative and end of life care, and** review the delivery model for social care, the contract for dentistry, and the public/ voluntary funding ratio for palliative care.
- Prioritize Public health's crucial role, enabling effective collaboration with primary care, to improve disease prevention, management and control, and deliver improvements at an individual and population level.
- Raise investment in the services impacting the social determinants of health -income support, good jobs, housing , early years, education and others. (Marmot)

Sources

- *Alderwick Hugh, et al Impacts of collaboration between local healthcare and non-healthcare organisations and factors shaping how they work: a systematic review of reviews, Health Foundation et al. BMC Public Health, (2021) 21:753*
- *Commonwealth Fund, 2021. Mirror, Mirror: reflecting poorly.*
- *Cowling TE et al. Contract and ownership type of general practices and patient experience in England: multilevel analysis of a national cross-sectional survey. JR Soc Med 2017;110:440-51.*
- *Doctors in UNITE, 2020, Public health and primary care*
- *Financial Times, 070223. Experts seek ills for the chronic ills of the NHS*
- *https://fullfact.org/health/accident-emergency-delays-excess-deaths/*
- *Goyal, DK et al. Restricted access to the NHS during the Covid 19 pandemic: is it time to move away from a rationed clinical response? The Lancet regional health – Europe https://doi.org/10.1016/jlanepe.2021.100201*
- *Health Foundation 2021. Levelling up in general practice in England • Health Select Committee, October 2022, The future of general practice.*
- *Institute of Health Equity 2020. The Marmot review 10 years on*
- *Institute for Public Health Policy and Research. Commission on health and prosperity 2022. Getting better? Health and the labour market.*
- *Irving G et al. International variations in primary care physician consultation time: a systematic review of 67 countries. BMJ Open 2017;7e017902.*
- *Kings Fund Jan 2021. Spending on public health*
- *Kings Fund 2019. A review of the West Suffolk Buurtzorg test and learn in 2017-18.*
- *Local Government Association (011022) NHS 'dental deserts' persist in rural and deprived communities.*
- *Markiewicz Ola, et al. Threats to safe transitions from hospital to home : NW London primary care. BJGP 2020;70 9690*
- *Marmot M, 2020 Health equity in England. The Marmot Review 10 years on*
- *Marmot M, in an interview with Andrew Marr. 19 April 2023*
- *Meirion Thomas J. Is it time to lift the medical student cap? Spectator 200822*
- *NHS 2022. Next steps for integrating primary care: Fuller stocktake report*
- *https://nhssomerset.nhs.uk/mineheadmedicalcent reemployeeownedtrust/*
- *OECD 2021 strengthening the frontline: how primary health care helps health systems adopt during the Covid 19 pandemic.*
- *OECD data 2021 https://data.oecd.org/healthres/doctors.htm*
- *Pereira Gray DJ, et al, Continuity of care with doctors -a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018. 10.1136/bmjopen-2017-021161.*
- *Rapaport, Lisa. Supply of primary care physicians linked with mortality rates.* bit.ly/2EgmCYu JAMA Internal Medicine, online February 18, 2019.

- *Royal College of General Practitioners 2022. Fit for the Future. Retaining the GP workforce, Fit for the Future: A new Plan for GPs and their patients.*
- *Sen Amartya 2016. Universal healthcare: the affordable dream. Guardian, 6 Jan 2015*
- *https://violationtracker.goodjobsfirst.org/parent/centene*
- *WHO and UNICEF, 010421. A vision for primary health care in the 21st century.*
- World Health Organisation. The case for investing in public health. A summary report for EPHO8

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