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Dear Mr Scott,

The New GP Contract

Although it has some positive features, I have five major concerns about the proposed Contract and key revisions to the Scottish Allocation Formula for General Practice. This letter summarises my key concerns and the critique that follows goes into more detail around those five concerns.

1) The failure of the new SWAF to address unmet need in the socially deprived Despite clear commitments from both the First Minister and the Cabinet Secretary for Health and Sport to match general practice resources with genuine *need* in deprived areas, and tackle inequalities in health using the new GP Contract and GP funding allocation formula, the new SWAF shifts very small sums to the most deprived practices. Meanwhile, feedback suggests that the IJBs are widely perceived to be finding it difficult to commission the integrated locality based teams that would be required to meet these needs. The inevitable outcome is the lost opportunity to achieve health gain in the socially deprived and increasing frustration felt by those GPs who witness unmet need and who are committed to doing something about it. Unscheduled secondary care services will continue to be disproportionately used by the socially deprived; emergency inpatient rates of hospital admission, which is of most concern to hospital managers, are more than twice as high in the most deprived quintile than in the most affluent. Health inequality will simply continue to widen despite hundreds of persuasive reports and copious rhetoric on the subject. Overall demand for health care will exceed our ability to fund it while unmet need will continue to rise.

2) Windfalls for the urban elderly practices, which tend to be affluent Despite the lack of wider debate, the lack of an evidence base, and the lack of discussion within TAGRA's oversight of the SAF Review, to underpin or support a move in this direction, substantial increases in funding have been promised to many urban practices characterised by elderly patients, which tend to be affluent. The weighting within the SAF has always been much higher for age than for deprivation; it will now become even higher.

The combination of 1) and 2) make it more likely, not less likely, that the inverse care law will be reinforced.

3) The accounting raid of rural general practice The substitution of an earnings protection payment for the excess cost of supply adjustment constitutes an 'accounting raid' on the funding of rural general practice. In my view, this was drastic and inexplicable and was never alluded to, never mind debated, within the TAGRA oversight of the SAF Review. Given that existing data sources suggest that personal income is lower amongst rural GPs than urban GPs and that GP numbers are

falling far faster in rural than in urban areas, probably as a result of personal income differentials, it seems counter-intuitive to alienate the rural GPs in this way. The New West of Scotland Health Needs Assessment Report I am currently completing reveals that the standardised mortality ratio is deteriorating in the rural boards within this region, while that of GG&C is improving. Providing unexpected financial windfalls to the affluent urban practices in the Central Belt at the same time as introducing a new formula that can reasonably be expected to cause a further loss of GPs in rural parts of Scotland is difficult to justify.

The combination of 1), 2) and 3) have left many GPs extremely disillusioned by the new proposals. Rural GPs are worried about retaining the funding for their added costs (now outside the SWAF) while Deep End GPs are worried about obtaining the additional funding to address the added costs involved with addressing unmet need - in both cases, the GPs have concerns about whether their IJBs will be able to deliver the targeted resources that are needed.

4) Timing of the release of the SWAF and use of public monies to influence a vote It is quite extraordinary that £23m worth of public monies can be used to influence GPs to vote for a New Contract that should be judged on the basis of its own merits. The fact that 68% of partners belonging to 63% of practices, most of which are urban, received increases in funding raises the possibility that negotiators are using the SWAF to secure the vote and the smaller group of rural GPs were universally disadvantaged to achieve that. The increasing concerns expressed by rural GPs reinforces my worry about this decision to redistribute resources. Bearing in mind the fact that real terms pensionable income has been falling since 2006, as demonstrated in a local study of GG&C incomes, and in keeping with the falling real terms funding of general practice across Scotland, it is entirely likely that the GP partners on the receiving end of the windfall, which amounts to a potential *average* pay rise of more than 10%, will indeed regard this additional funding as personal income, with no benefit to patients, and certainly little or no benefit to either patients in deprived areas or elderly patients.

The gainers' freedom to pocket the extra resource as personal income discredits the whole system – highlighting the need to separate how GPs are paid from how their populations' needs are resourced, as shown below.

5) Phase 2 – The need for regulation of personal income in general practice The elephant in the room where any discussion of general practice takes place is the overwhelming need to regulate personal income in general practice. GP partners are still free to decide how much of their practice income is spent on expenses related to service provision and how much they take home as personal income. There will be a reluctance to target and better fund GPs looking after vulnerable patient groups in their care (addressing unmet need in deprived areas described in item 1) above is just one example, unmet need in rural areas is another, vulnerable patient groups such as asylum seekers is yet another). Less obvious but equally important is the ongoing insidious damage to inter-general practitioner relationships that results from large variation in personal income amongst neighbouring GPs. Of most relevance to the current debate is the fact that the wide variation in personal income is a major hindrance to the successful cluster working on which the New Contract depends.

The lack of transparency maintained by both the government and the BMA in relation to data on personal income in Scotland must come to an end, as it has done south of the Border. In my view, historically, neither the BMA, the health boards, nor successive governments have taken sufficient notice of this issue or monitored or controlled high income earners. The combination of uncontrolled personal income maximisation and absence of relationship between income and performance ensures that no government will ever want to properly fund general practice, the key gatekeeper to the entire NHS. I believe that the inability of successive governments to solve this issue is a key reason the entire NHS is facing insurmountable challenges controlling demand for secondary care.

As a result of the above concerns, my advice to the GPs during this critical time was to resist the temptation to accept the financial inducement and to vote against phase one. They should also have demanded that the SGPC negotiating team adopt a more open and democratic approach, one that encouraged a debate of what are complex issues. The relative state of ignorance of the GP body, as well as the lack of viable alternative proposals, the strong emphasis on the positive aspects of the New Contract regarding promises to reduce both risk and workload, and the financial inducement accompanying the ballot paper that so many of them received, are the main reasons that GPs will have voted for phase one.

Given that all signs indicate that phase one will be voted through, it is left to me to make my concerns known to you so that the Scottish Government is made aware of the need to go back to the drawing board, re-review the SAF and offer a third option. Neither the status quo, nor the offer currently on the table, is acceptable. This third option can only be achieved through open discussion with representatives from all camps including the Deep End, the rural, the remote, the affluent urban elderly, and any others. That open discussion should be underpinned by open and rigorous scrutiny of all the evidence, including personal income data, which should be widely available to all.

My prime purpose in writing this letter to you is to inform you that I am concerned that TAGRA has been used to legitimise a flawed formula in order to secure a 'yes' vote on the GMS contract that will not improve primary care provision across Scotland. I ask you to consider calling on your Finance colleagues in the Scottish Government to reconvene the group to consider my evidence and advise the Scottish Government based on the new evidence that a new approach is required. I would welcome the opportunity of being involved in this work.

I would also appeal to you to share this correspondence with all members of the SGPC negotiating team including Dr A McDevitt, Dr A Buist and Dr A Cowie in advance of their meeting with LMC chairs tomorrow (18th January). It is important that, collectively, they consider these issues in advance of any irretrievable decisions. Given how quickly things are developing just now, I would really appreciate a prompt response.

Yours sincerely

Helene Irvine

Dr Helene Irvine
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Member of TAGRA during the SAF Review

Copies to:

Dr L Decaestecker, DPH, Dr E Crighton, Head of Health Services Section, Public Health and Health Improvement Directorate, NHSGG&C.

A public health perspective on the new SWAF and New GP Contract

The failure of the new SWAF to address unmet need in the socially deprived At FMQ on 3 December 2015, Nicola Sturgeon stated that "further changes will be made to the 2017 contract, which will include a review of the Scottish resource allocation formula, to ensure that GP surgeries in the areas of most *need* receive funding that is proportionate to the needs in their areas." On 15 December 2015 at a government-sponsored debate entitled *Redesigning Primary Care,* Shona Robison stated that "we need to ensure that all the challenges that are faced by those practices operating in more deprived communities are recognised in the resources that are provided to primary care....and that the new contract provides...the opportunity to go even further to tackle health inequalities in communities". Ms Robison then sent an email to Nicola Sturgeon on 6 January 2016 where she acknowledges that 'tackling health inequalities is a key priority' and that the SG is in regular contact with senior representatives from the Deep End group of practices' and that 'we will take full account of Professor Watt's findings as we deliver a new GP contract for 2017 and the accompanying revised allocation formula'. Despite these commitments from senior politicians, and bearing in mind the large published evidence base on unmet need in deprived areas produced by Graham Watt and many others brought to the attention of the SAF Review by Prof Watt, Prof Stewart Mercer and myself in extensive correspondence during 2016, the negotiators of the New GP Contract make clear that the new SWAF is a workload model based on consultation and Read code rates that does not address unmet need.

It was clear during the TAGRA meetings that the civil servants took the advice from the SGPC chair not to explore and address unmet need in primary care and ways to measure it in the context of the SAF formula, the way TAGRA experts such as Karen Facey had done in the context of the NRAC formula. This very different approach to the two formulae needs justification, as does the authority of one person in the BMA to unilaterally make such a fundamentally important decision without having to account for it. Despite assurances by negotiators that additional resource will be shifted to the practices in deprived areas, the actual sums involved for the 50 most deprived practices in GG&C average out to a modest 3.2% increase, according to the allocation file released by the SG.

Windfalls for the urban elderly practices, which tend to be affluent

Meanwhile, the same allocation file reveals that those urban practices characterised by high concentrations of elderly patients, which tend to be affluent given the increased longevity that accompanies affluence, have received substantial sums of increased funding. In GG&C, of the five most 'affluent practices', four received additional practice funding, ranging from 4.0 to 10.1% of their gross income. Despite the reassurances from senior politicians to address health inequalities and ensure "that GP surgeries in the areas of most *need* receive funding that is proportionate to the *needs* in their areas", and the absence of reference to the alternative aim of addressing the higher *demand* for GP consultation by the elderly affluent highlighted by the PTI dataset and shown in the graph I shared with the SAF Review in October 2016, the bulk of the £23m has been allocated to affluent urban practices. This alternative aim of increasing the funding to urban elderly affluent practices, in order to address what are clearly outlier rates of *demand* as opposed to *need*, was never discussed at the TAGRA meetings, nor was an evidence base submitted to justify any decision to move in that direction. Copies of separate correspondence between myself and a GG&C Primary Care Manager dated 17 January 2017, copied to the civil servants involved with the Contract negotiation, where I provide credible epidemiological evidence arguing against the shifting of resources from practices characterised as 'younger deprived' to those characterised as 'elderly affluent', are available on demand. This suggests that carefully analysed and interpreted data managed to protect the younger deprived practices to some extent in this process but at the expense of those who were minimally represented at the TAGRA meetings where the SAF review was presented, i.e. the rural practices, which have their own version of unmet need, which also went unmeasured.

The fact that the new SWAF does very little to address unmet need in the socially deprived and may even exacerbate the inverse care law by providing windfalls to the affluent urban elderly practices, will be addressed by the Deep End Steering Group. It has issued a Position Statement on this subject raising credible concerns that defy many Government policy documents aimed at reducing inequality in health. I wrote to the TAGRA Chair twice in relation to the SAF review, in April and October 2016, about the need to use the funding of general practice to address the inverse care law; it never occurred to me that the TAGRA Chair would oversee a process (the SAF Review) that might actually make it worse.

<u>The accounting raid on the funding of rural general practice</u> The substitution of an earnings protection payment for the excess cost of supply adjustment is drastic and inexplicable. In my view, it was done with insufficient effort to come up with a robust replacement for the adjustment for excess cost of supply. Whilst attending the relevant TAGRA meetings, I noted that far too little time and effort was afforded to studying this aspect. Those present at these meetings will recall that I consistently expressed the view that the excess cost of supply adjustment was historically too generous and argued that case at the meetings and in writing to the TAGRA chair. However, removing it altogether after so little effort to come up with a replacement is unfair. It means that the rural GPs are bound to be very unhappy with what appears to be 'on income support' status where they are vulnerable to reductions in revenue on the grounds that they are being heavily subsidised by an MPIG equivalent. GPs are well aware of the vulnerability of current MPIG funding and will not be assured by statements that they are protected indefinitely, particularly when funding decisions transfer to the heath board or HSCP.

Furthermore, I am concerned that this decision to downgrade the excess cost of supply adjustment was made in the absence of oversight by TAGRA, either before or after the decision to step the group down and bring its role in overseeing the SAF Review to an abrupt end. I suspect that the TAGRA membership, whether appointed from urban or rural, deprived or affluent health boards, would have objected, as would the statistical sources of expertise within TAGRA. In fact, effective representation of rural interests was minimal or absent during the discussion of the SAF Review at these TAGRA meetings, implying that my strong representation of the interests of the socially deprived was not matched by similar representation of those in rural areas.

Correspondence from the Professor of Primary Care and Rural Health at the University of Aberdeen, dated 31/12/2017, also substantiates my own observations of the SAF Review overseen by TAGRA, with respect to the inadequacy of the key dataset. There has been an excessive reliance on a simple workload approach that counts Read codes or consultations based on an outdated and unrepresentative dataset (PTI). This approach will inevitably reward the GPs that are serving high rate users of general practice (*i.e.* the affluent elderly who are concentrated in the urban areas) but makes no adjustments for the nature of consultations in rural areas where A&E departments are less accessible and far more minor injury surgery and immediate/urgent work is taken on by GPs. This approach is bound to underestimate the workload in rural areas.

Per capita GP numbers are falling far more rapidly in the rural and remote areas than in urban areas and it is likely that this will be accelerated with this change in the funding, which will now be perceived as more precarious. The New West of Scotland Health Needs Assessment I am writing demonstrates a clear rise in standardised mortality ratio in the rural health boards of this region that will not be helped by any further reduction in GP numbers. The real concern of remote and rural GPs, that in future their numbers will be curtailed further based on the SWAF, is legitimate.

The evidence from both the NHS Digital dataset on HMRC GP income in the UK and the Deloitte report on the same subject for Scotland suggests that remote and rural GPs earn less, on average, than urban GPs, so it seems paradoxical that we would carry out an ‘accounting raid’ on the rural GP funding and demand a higher standard of financial accountability in relation to expense claims from

them with the new GP Contract than we will demand from urban GPs. This has become particularly relevant in light of the analysis of pensionable income in GG&C GPs, described below, who are almost entirely urban.

In fact, it is hard for me to understand why, given the relatively small amount of monies raised by the elimination of the excess cost of supply adjustment and yet the major discomfort it causes to the affected GPs, who are largely rural, this decision has been made. Unless it was done to use up the sums put aside to award to GP pay rises generally and justify the sums required to positively influence the urban GPs, who are in the majority in terms of numbers, to vote in favour of the Contract. I realise this view is contentious but the opportunity presented by a £23m investment in General Practice to result in the alienation of GPs working in remote and rural Scotland defies any other logic.

Timing of the release of the SWAF and use of public monies to influence a vote

I am concerned that the timing of the release of the SWAF, and the allocation letters describing increases to gaining practices that are deemed to be calculated by the SWAF, are designed to try and appease both urban deprived and urban elderly affluent in the Central Belt to the detriment of the rural and remote practices. I believe that these were issued just before a critical vote to induce the 68% of GP partners who belong to the 63% of practices who are on the receiving end of a rise in funding, *dependent on majority support in the poll*, to vote for phase one. The civil servants advise me that the GPs first had sight of the Deloitte reports in late November, a matter of weeks before the close of the vote on 4 January 2018, when they were published more than a year previously in August and November 2016. Surely, a more robust approach leading to a more valid ballot result would have allowed the GPs time to actually read and assimilate the 4 relevant reports (The 2018 GMS Contract in Scotland, Deloitte Workload, Deloitte Excess cost of supply, and Deloitte Earnings and Expenses). Rural GPs advise me that they would have raised concerns much earlier about the efforts made to adjust for rural workload and excess costs of supply if they had had access to these reports much earlier; this might have influenced the process and decision-making.

I understand that rural/remote practices have been assured that they will not actually lose any funding in the short term as a result of the new SWAF. Nevertheless, I believe it was entirely inappropriate to use the funding formula and positive increases that reportedly flow from it, to promise revenue increases totalling £23m to almost 70% of GP partners, just before a critical vote on such an important set of changes to general practice. The latter should be judged on their merits and not in the light of a financial inducement.

Given that average real terms pensionable income for all GPs has been falling since 2006, it is very likely that much or all of this additional funding will be channelled to personal income. The £23m invested to fund this 'financial inducement' amounts to an average potential personal pay increase of almost 11% for those GP Partners on the receiving end, which is very large, and is unlikely to be used to invest in more GPs or nurses for many or even most practices. In GG&C, four out of the five most ‘affluent practices’ received additional funding that amounts to a potential personal pay rise ranging from 6.5% to 16.4%. Needless to say, it is likely they will have voted for phase one in these circumstances. If the DDRB were to sanction a pay rise to GPs it would have been much smaller (1-3%) and be available to all GPs, not excluding those who ended up with payment protection as a result of a workload formula that fails to measure the additional work involved with rural patients. I believe that the average tax payer, including nurses and non clinical staff, would be unhappy about this if this was to be revealed for what it is. This also does not fit with the Scottish Government Budget 2018 intention of limiting pay rises for public sector workers earning over £80,000 to 1%.

That, combined with the freedom to practice 'income maximisation', as described in the final section below, means that some GPs who have a tendency to consistently earn more than the mean income, will simply earn even more money than before with no demonstrable benefit to the NHS.

In contrast, the BMA/SG are emphasising the low income earners in their promotion of this contract, presumably to attract more support, and make no mention of the problem at the other end of this spectrum, namely the high earners. This is ironic given inopportune comments from civil servants in my presence that 'the government would never put another penny into general practice as long as some of them were making over £200,000'. Low income earners never got a mention in these discussions. If the SG was genuinely concerned about low income earners, they would not have consistently disinvested in general practice since 2006.

The problem associated with insisting that a new funding formula and a New GP Contract be bound and issued together in the way negotiators have done is that they will always be very tempted to interfere with the formula in a novel way that enables them to find target groups to resource and tempt with shifts in funding; on this occasion it is the affluent urban elderly accompanied by a token shift to the socially deprived. The formula is *supposed to be* a scientific, evidence-based, analytical tool; its successful design requires considerable intellectual and financial resource. If the architects of the formula genuinely believe that it is sound and fair, it should be imposed on GPs, who the civil servants admit to me 'don't understand it anyway' rather than be used to win a vote. The latter aim will influence the modelling process and bias the selection of the model from a range of possible models. It means that 'behind the scene adjustments' have to be carried out to ensure that the formula can be sold as a genuine workload formula whilst spreading limited resources to enough GPs to buy their vote. What if a fairer, more evidenced- based formula distributed the additional resources to only 40% of practices rather than 63%? The negotiators would not have been keen on using it for obvious reasons; it would be less likely to secure the vote. This puts an inevitable question mark above the formula's validity and it should not surprise us that so many GPs are describing it as 'flawed'.

Furthermore, students of history will recall that the 2004 Contract was associated with a large increase in GP funding, that was no doubt aimed at inducing GPs to vote for it, and that resources were clawed back, just two years later, starting in 2006, falling ever since. This should be a lesson to all GPs to avoid being duped into voting for a Contract that is not in their long-term interests, or indeed the wider NHS' interests. I fear that we are about to see GPs vote in another flawed Contract with which we will have to live for another 10-15 years until the next Review. As such, I feel obliged to object to this use of public funds.

<u>Phase 2 – The need for regulation of personal income in general practice</u>

Assuming a majority vote for phase one, there is a possibility that GPs will <u>not</u> vote for phase two and that income regulation will never come into being in any meaningful way. The GPs I have informally surveyed in Glasgow, many of whom were on the receiving end of a rise in income, advise me that they will be voting for phase one but voting against phase two. The financial incentive described above will have played a major role for the support of phase one. The fact that many GPs are still wedded to the independent contractor (IC) business model (>80%) and fear that any control of income amounts to loss of IC status, autonomy and efficiency will be playing a major role for the lack of support for phase two.

An analysis of pensionable income in GG&C over a ten year period, the first of its kind in the UK, shows a statistically significant fully adjusted correlation between social deprivation of the patient list and pensionable income per GP partner. There is no logical explanation for that correlation given that the additional funding for deprivation is given to help GPs provide a service. The work also shows much wider variation in pensionable income per partner at the deprived end, than at the affluent end, with some 'deprived GPs' earning very modest sums and some 'deprived GPs' earning a lot by anyone's standards. This wide variation is both intuitively undesirable and a sign of poor financial governance. This analysis suggests that GPs who work in deprived practices are a mixture of those committed to offering a good service and subsidising that service using their own incomes; and GPs

who focus on minimising their expenses and maximising their profit by working single handed with large list sizes and minimal supporting staff.

This analysis also shows that 'personal income maximisation' has fallen since a peak in 2010, when one GP in a deprived practice earned over £300,000 pre tax personal income, the decline probably due to global disinvestment in general practice. I believe that 'income maximisation' will rise again if money is invested in general practice, including via the £23m windfall, without regulation, capping or some alternative control on personal income. In fact, the large and counter intuitive pay increases seen for some practices in the recently circulated Excel allocation file are expected to have dramatic impacts on pensionable income for some of the 'winning practices'. The fact that most rural practices, which on average earn lower pensionable incomes than urban practices, were excluded from this windfall and restructured using variable percentage of 'income and expenses protection' in the face of income maximisation in a significant minority of GG&C practices in deprived areas, seems unacceptable to me. This is notwithstanding our ongoing commitment in GG&C to ensure that more primary care resources are made available to the most deprived populations.

Finally, one of the most disappointing aspects of my work on this topic relate to the discovery that there seemed to be little appetite on the part of either the BMA or the SG to consider the findings of our analysis of pensionable income in GG&C and in fact a desire to suppress it altogether on the grounds that its release is in no one's interest. I believe the taxpayer would beg to differ. The attitude from officials involved with the negotiation in Scotland contrasts dramatically with the strongly held views of many GPs, including Deep End representatives, with whom I have shared the analysis who insist that its dissemination is overwhelmingly in the public interest and that it, therefore, must be published. I believe that the lack of transparency around most aspects of general practice and its funding is the fundamental reason for any dysfunction and the division that is rife in the profession. The wide variation in personal income is a major hindrance to successful cluster working on which the New Contract depends. Sharing the findings constitutes the strongest argument there is in persuading GPs to move to some form of income regulation, including outcome/performance related pay structures, preferably whilst retaining the many benefits of the independent contractor. Jobbing GPs themselves need to be encouraged to take a greater involvement in coming up with the solutions once they have been shown the full nature of the problem.

On 29 December, the Times wrote about the results of an FOI request by Taxpayers' Alliance that describes income maximisation in England and Wales, where one GP earned more than £700k pre-tax personal income (https://www.thetimes.co.uk/article/make-family-doctors-reveal-their-pay-mps-demand-3w9t98zqd). It makes clear that this issue has been made public south of the Border, where it is much easier to obtain similar data. Although the problem of income maximisation is more extreme in England, there are valuable lessons to learn from south of the Border.

I was hoping that the New GP Contract would contain the necessary provision to prevent or at least control 'personal income maximisation' that is both unjustified and unrelated to practice performance. The ability of the NHS to effectively target general practice-based resources where they are most needed depends critically on the ability of the SAF and its replacement to allocate funding to those patient lists where it is most needed. Without income regulation, systematically targeted funding becomes impossible, leaving the HSCPs to pick up the pieces in ad hoc fashion, and personal income maximisation, resulting in squandering of scarce resources, is facilitated. As the two phase introduction offers no guarantee that income regulation will be introduced in this New Contract, I feel obliged to summarise the evidence on Pensionable Income in GG&C at same time as I highlight other serious deficiencies in the negotiated proposals.