PE1845/J
Professor Philip Wilson submission of 4 February 2021

I write in support of Galloway Community Hospital Action Group's petition for the establishment of an agency to advocate for the healthcare needs of rural people. I am a GP with 33 years' experience and have been professor of primary care and rural health at the University of Aberdeen for nine years. I am closely involved with the work of general practices in rural Scotland and am research advisor to the Rural General Practitioner's Association of Scotland.

I wish to use a single example to illustrate the need for an agency close to government with responsibility for rural health care: the introduction of a new GP contract in 2018. This contract was agreed between the Scottish General Practitioner's Committee of the British Medical Association and Scottish Government negotiators, and was adopted following a poll in which around a quarter of GPs voted in favour. It is widely considered to have had disastrous consequences for the sustainability of remote and rural general practice. The Public Petitions Committee was previously involved in discussions about this contract (PE1698).

The 2018 GP contract covered many aspects of general practice and primary care, but two key developments were the allocation of new funding for practices and the appointment of Board employed staff to enhance the role of a broader primary care team.

The allocation of new funding was based on a bizarre methodology that equated numbers of consultations offered with underlying medical need. In this way well-staffed practices in urban areas were rewarded well (around £10,000 additional funding for each central belt GP on average) and the allocation to the most remote practices was greatly reduced. All previous funding formulae had included specific payments to rural practices to reflect the fact that a much broader range of services were provided generally to a smaller number of patients over a larger area.

Rural.GP.Scot has published a map which illustrates the 'gainers' from the new contract in green and the 'losers' in red. Although there was a nominal commitment that no practice would actually be worse off, the additional funds provided to urban practices meant that, given the very limited number of GPs in the job market, recruitment to rural practices became much more difficult. Nevertheless, the votes of GPs likely to gain substantially from the formula would have been more than sufficient to endorse the contract.

The allocation of Health Board employed staff to support rural general practice has been extremely problematic. It is logistically easy to provide physiotherapy, pharmacy or nursing support to urban practices but providing a meaningful resource to the most remote practices has proved to be nearly impossible – so once again rural practices have lost out.

There have been attempts made to remediate some of the damage caused to rural and remote practices by the 2018 contract. Scottish Government appointed Sir Lewis Ritchie to lead a shortlife working group on rural practice, later to become a standing working group – but the Terms of Reference provided to this group prevented it from

examining the underlying principles of the contract or the allocation formula, and the group has not in any case met for a year.

The original consultation documents presented to GPs in 2017 held out the prospect that GPs would be allowed to continue to provide services or to employ staff where these could not reasonably be provided by Boards – but practices seeking permission to offer devolved services in this way have in almost all cases been met by refusal by Scottish Government on the grounds that the proposals are not in line with the principles of the contract. Rural practices offering services that Boards are unable to deliver are therefore given the invidious choice between withdrawing a service their patients previously enjoyed or continuing to provide it without funding or any of the resources available to urban practices.

It may seem surprising that such a grossly unfair contract could ever have been negotiated, let alone implemented. It appears that an urban-centric BMA negotiating team was willing to sacrifice the interests of rural colleagues and their patients for what it saw as the 'greater good' (see letter from Dr Helene Irvine within PE1698/E) and the government negotiators were willing to agree a deal on this basis.

In my view, a Rural Health Commissioner with access to the policymaking process would almost certainly have prevented or mitigated the damage caused by the 2018 contract – by simply asking forcefully what its impact on rural patients would be. An excellent model for this role has been created in Australia, and the position of Scottish Commissioner for Children and Young People offers a good organisational template for Scotland.