RCGP SCOTLAND

The Scottish GP Workforce and Socioeconomic Health Inequalities

2024

Executive Summary

The health of the Scottish nation is heavily undermined by its health inequalities. While we have good evidence and understanding of the challenge, there has been a sustained failure to resource and implement change where it would be most effective - in primary care - but also other NHS sectors including secondary care.

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We require more overall resource for general practice to allow for targeting according to population need without negatively impacting on other GP provision. There needs to be specific solutions for the most deprived areas, as well as an increased focus on health inclusion in medical teaching and training, if recruitment and retention at the Deep End is to be properly supported.

The evidence shows there is a shortfall of GPs and other staff in Scotland's most deprived practices, and such practices are less likely to have capacity to train staff largely because of workload. Both patients and GPs in deprived practices are more stressed and have more to do in consultations, with poorer outcomes than in less deprived settings.

We need to continue to embed and enable inclusion health learning into undergraduate teaching and foundation years, GP training, and fellowship programmes to better account for the needs of general practice serving socio-economically deprived populations.

As with general practice more generally, it is imperative that the day-to-day working lives of clinical staff improve, powerfully and quickly. Without that, we will see worsening of both recruitment and retention, and that is likely to hit the under-served practices hardest, where the health service, and patients, most need their GPs.

The Scottish GP Workforce and Socioeconomic Health Inequalities

RCGP Scotland recommendations

1. General practice has a key role in the mitigation of Scotland's poor record on health inequalities. There should be greater investment in general practice so that it receives at least 11% of NHS funding, with a review of all funding streams to channel more spending to the areas of greatest deprivation in line with proportionate universalism principles.

2. The Scottish Government should commit to the growth of the GP workforce in recognition of its key role in addressing health inequalities through meaningful workforce planning by Whole Time Equivalent figures and not headcount.

3. Barriers to teaching and training capacity which perpetuate the inverse care law should be assessed and addressed.

4. Learning about health inequalities can be embedded from the beginning of medical careers. Inclusion health should be a core element of undergraduate teaching and postgraduate training.

5. The participation and attainment gap between students of the highest and lowest socio-economic backgrounds, should be reduced. In pursuit of this, there should be an outcomes analysis of the socio-economic status of those entering Scottish medical schools.

6. The Health Equity Focussed Training programme should be available for those GP trainees who want to work in areas of deprivation, with health inequalities having a higher profile in all GP training.

7. Deliver a Scottish fellowship for those GPs working in practices serving deprived populations.

8. Sub-analysis of Scottish GP workforce and workload data in terms of practice deprivation status should be routinely undertaken by Public Health Scotland to demonstrate the complexity and requirements associated with deprivation.

9. The Scottish Government should provide the resource and time for GPs to undertake reflective practice, in recognition of the high emotional labour of working in deprived practices. Ultimately this should be available to all GPs.

10. We must see the full implementation of the recommendations of Scottish Government's Primary Care Health Inequalities Short Life Working Group.

The scale of the problem

"Since the 1950s, Scotland has had the lowest life expectancy of UK nations and in recent decades its position has deteriorated relative to other western European countries… the cost of inaction in Scotland is simply too great to contemplate... We do not need another grand strategy. We need practical collaboration, up and downstream."

The state of health and health inequalities in Scotland: an independent review. January 2023. The Health Foundation.[1]

These were the conclusions of a multi-agency research group, co-ordinated by the Health Foundation, in January 2023. The group also reviewed the history of Scottish health inequalities since 2000 and concluded that "…despite well intended policy interventions, the gap in health and wellbeing outcomes is widening...Scotland has the lowest life expectancy in Western Europe."[2]

In addition, we are now seeing the worrying emergence of two-tier systems of healthcare, as those who can afford to opt out of waiting times and access problems, do so. This demonstrates the full Inverse Care Law, first described by Dr Julian Tudor Hart in 1971, "the availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced."[3]

Long term monitoring of health inequalities in Scotland shows:[4]

- The Relative Index of Inequalities (RII) has increased to its highest level since the start of the time series for both males and females, increasing from 0.38 to 0.47 for males and from 0.36 to 0.45 for females between 2013-2015 and 2019-2021.
- The absolute gap in Healthy Life Expectancy (HLE) has also increased since the start of the time series for males and females. For males it has increased from 22.5 years in 2013-2015 to 25.8 years in 2019-2021. For females it has increased from 23.8 years in 2013-2015 to 25.7 years in 2019-2021, the largest gap in the time series.
- HLE is a quarter of a century shorter in the most deprived tenth of areas in Scotland compared to the least deprived tenth of areas.
- In terms of mortality, those living in the most deprived fifth of areas are at least twice as likely to die from almost every cause examined as those in the least deprived fifth, and for some outcomes, such as the deaths of despair, these inequalities are far greater.

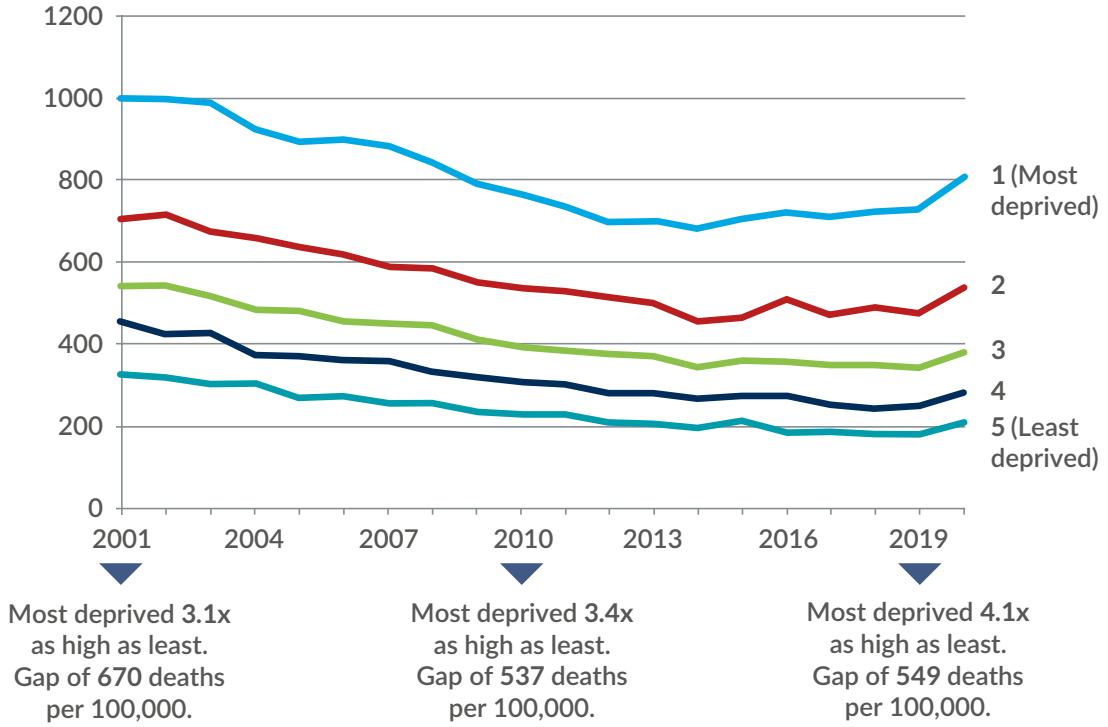
Inequalities utterly dominate Scotland's health landscape, with stark and unfair outcomes in health and wellbeing across the population, and life expectancy now falling for the most socioeconomically deprived. Poverty is key and is worsening, and the Health Foundation found that "strong association between income and health… has potentially grown stronger in Scotland in the past decade." In other words, the poorer are now suffering worse ill health than previously.

In terms of mortality, the leading causes of avoidable deaths are consistently: cancers (29%), diseases of the circulatory system (25%) as well as alcohol and drug related conditions: the everyday work of Scottish general practice, especially in deprived areas. The inverse care law continues to operate, "inequalities have remained large, and men and women living in the most deprived fifth of areas are 2-3 times as likely to die from causes that have been classified as being potentially preventable by treatment and secondary prevention as those living in the least deprived areas."[5]

The Health Foundation's analysis is also that those in the most deprived quintile are faring worse - by far - and that drugs and alcohol continue to be powerful drivers of premature ill health. Premature morbidity and mortality correlate with missed appointments both in general practice and outpatient clinics, the latter pushing work - and risk - back to GPs.

The Health Foundation's report highlights that there are "especially high inequalities for causes of death that are avoidable (i.e. are treatable through healthcare or preventable through healthcare and policy action), particularly the so-called deaths of despair." The 'deaths of despair' are those which are drug-or alcohol-related or probable suicides. Improvements in 'avoidable mortality' - where we can make a difference - have stalled, and avoidable deaths are actually increasing in the poorest. This summarises the situation for Scottish men:

Male avoidable mortality rates, per 100,000 population, age standardised, according to fifths of area-level deprivation: 2001 to 2020.



	2001	2004	2007	2010	2013	2016	2019
Population average (per 1,000)	602	540	494	434	397	395	380
Relative difference	3.1	3.0	3.5	3.4	3.4	3.9	4.1
Absolute gap (per 1,000)	670	621	629	537	493	535	549

National Records of Scotland. Avoidable Mortality 2020. Edinburgh: National Records of Scotland, 2022.

In 2020 it is estimated that just over a quarter (27%) of deaths in Scotland were avoidable through timely, effective healthcare and public health interventions, and Scotland has higher avoidable mortality rates (336 per 100,000) than England or Wales.[6] Prior to the pandemic, Scotland's health inequalities - which largely determine its health record - were worsening, but Covid-19 hit the poorest hardest, for multiple reasons, and has widened inequalities yet further.

The Role of General Practice

The Scottish Government is aware of the dominating influence of health inequalities and is keen to reduce them and has included in its Realistic Medicine programme and Care and Wellbeing portfolio. However, there is, what The Health Foundation describes as a "persistent and growing implementation gap". We have seen a failure to expand and develop what is most likely to help in terms of health care delivery, namely a systematic and considered development of general practice.

Professor Sir Michael Marmot said in his evidence to the September 2022 meeting of the Health, Social Care and Sport Committee, that the "discrepancy between the positive rhetoric in Scotland about tackling health inequalities and the reality is that rates of health inequality in Scotland remain worse than in England." He added that "If you have the right policies, they have just not been applied deeply enough and for long enough." It is unfortunately all too evident how this applies to Scottish general practice, which could offer a highly effective, evidence-based option for a deeply intractable problem.

Research has demonstrated that because of austerity pressures, Scotland failed to maintain the additional increases in spend on health care it needed for its population demographics.[2] There is cause for the NHS to concentrate especially on the most deprived quintile, and practices with blanket deprivation, if the NHS is to be at its best where it is needed the most.

In April 2023, the First Minister announced an additional £1 million of funding to the 81 NHS Greater Glasgow and Clyde Health Board area practices that feature on the list of 100 most deprived practices in Scotland, and we want to see the expansion of initiatives like this. Health services make a difference, even when the causes of inequalities are upstream factors.

A strong primary care workforce reduces health inequalities and improves population health,[7] and yet we have an overall GP workforce shortfall in Scotland, and one that is relatively depleted in areas of deprivation, due to both recruitment and retention issues.

The Health, Social Care and Sport Committee published a report in 2022 'Tackling Health Inequalities in Scotland which "urges the Scottish Government to ensure the impact on inequalities and health inequalities is a primary consideration in the future design and delivery of all public services."[8] That surely must apply to general practice with its key role in mitigation and providing local accessible services. If we are to succeed in that, we need to urgently recruit, retain and develop the primary care workforce.

The Committee also called for consideration of a Health Inequalities Impact Assessment for all public policy development. We need to not only assess for protected characteristics but also for socio-economic status.

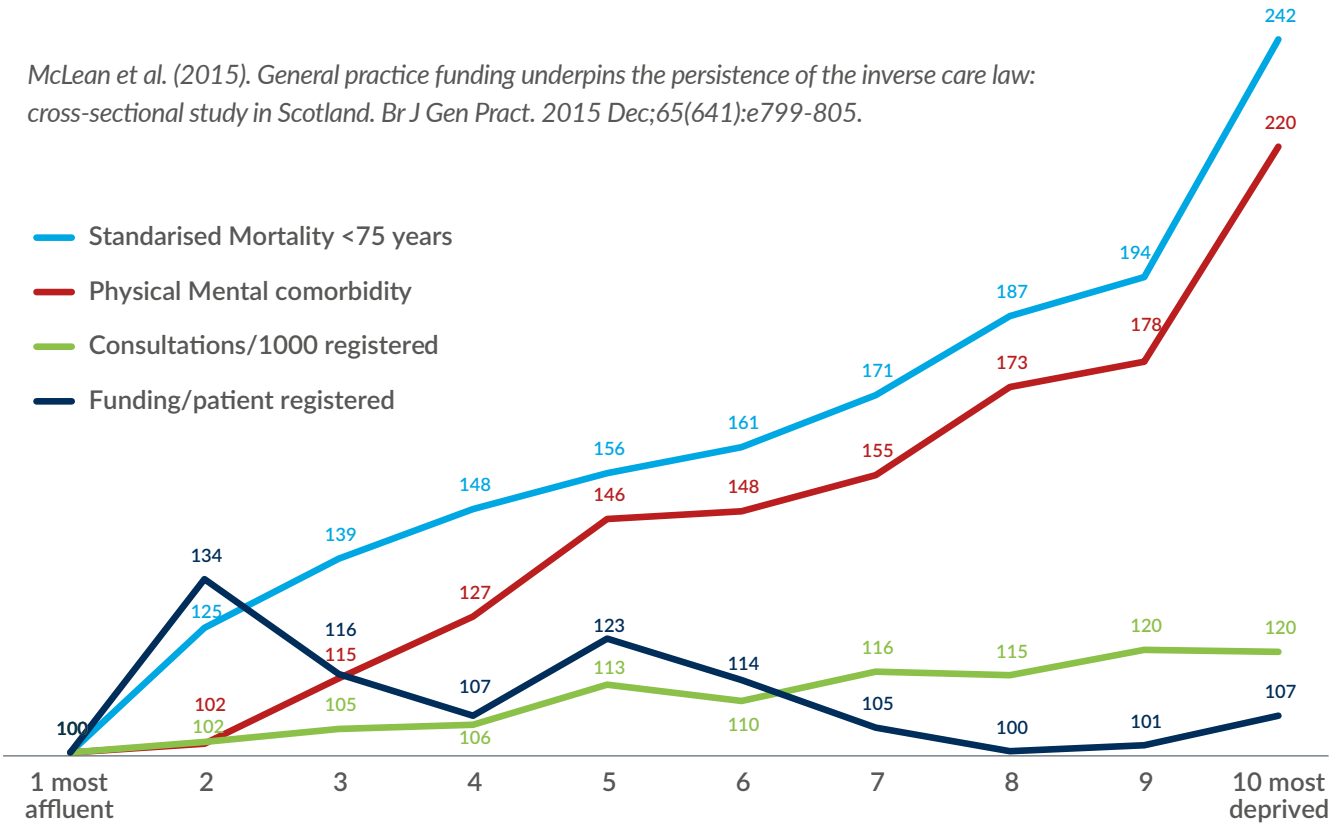
Arguably, this is even more important in the delivery of health care itself and should be a powerful factor in determining what kind of GP services we develop, and how they are resourced. Instead, resource allocations to general practices are based on the GP Workload Formula, which is unlikely to fully account for the most deprived, and certainly does not account for increased complexity of consultations, nor unmet need.[9] Despite a stated intention to improve health inequalities, there is an emerging view that the new contract primary care arrangements are actually widening them.[10,11] We need to grow the WTE workforce overall, but especially in areas of deprivation in line with proportionate universalism principles. We need to monitor the outcomes of new interventions and models of care: in terms of the GMS contract, the question should be routinely asked whether health inequalities are being reduced in line with one of its explicit aims, and if not, why not and how we can change going forward.

We therefore need a systematic appraisal of what will best serve our most health-disadvantaged communities and seek to cost and implement that, accounting for the necessary workforce. Upstream public health measures are crucial, and many of those avoidable deaths relate to conditions where risk reduction and mitigation can exert powerful effects.[12] People with those conditions seek help from practices, where GPs and their teams also deliver extensive primary and secondary preventative care.

In short, we need better and more general practice in areas of profound socio-economic deprivation to reduce the ill-health and mortality our services can influence. We also need visionary new models accounting for social inclusion, with extended teams of link workers, enhanced receptionist roles and so on, allowing GPs to focus on the significant unmet need burden, including the 'unworried unwell', and the complex.

Scottish data has shown that multi-morbidity occurs on average 10-15 years earlier in the most deprived, with people in their early 50s having twice the prevalence of multi-morbidity in the most - compared with the least - deprived .[13] Patients with multimorbidity have higher levels of mortality, primary and secondary care usage, hospital admissions, frailty, and experience reduced quality of life.[14] Their care takes a lot of time,[15] particularly for behavioural interventions, which are especially challenging in deprived settings. The gradients in consultation rates, co-morbidity and standardised mortality (for those under 75) are very stark, with consultation rates 20% higher in the highest, compared with the lowest, deprivation categories:

McLean et al. (2015). General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland. Br J Gen Pract. 2015 Dec;65(641):e799-805.



The Health Foundation[16] outlines that "the effects of multiple forms of disadvantage can be greater than the sum of their parts when experienced together or in the harshest dosages" and concludes that there is cause for the NHS to concentrate especially on the most deprived quintile, and practices with blanket deprivation, if the NHS is to be at its best where it is needed the most. Health services make a difference, even when the causes of inequalities are upstream factors.

The GPs at the Deep End project, funded by Scottish Government, with administrative support from RCGP, has collated much of the evidence of the drivers of health inequalities and what is needed to address them.[17] Further consideration of the work of GPs serving deprived populations, and the needs of their patients, is detailed in the Scottish Government's Short Life Working Group report on health inequalities with its 23 specific recommendations,[18] emphasising that access is increasingly being recognised as a social determinant of health.

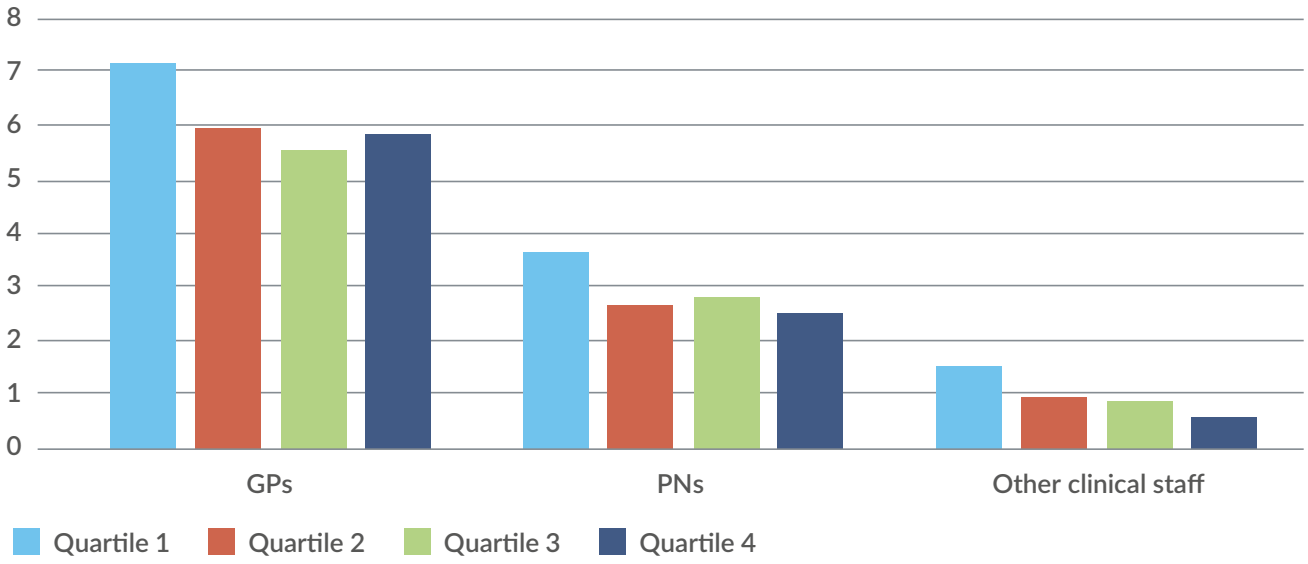
Impact on the workforce

The evidence is that GPs working in the most deprived areas of Scotland are struggling to keep up with 'Deep End' demand, let alone address unmet need with the evidence-based approaches we now have. GPs in such settings feel that they undertake additional complex work where healthcare systems and self-management strategies do not meet patients' needs,[19] creating an additional risk factor for GP burnout.

Despite the stated governmental aim of tackling health inequalities, a secondary analysis of the 2019 Scottish Workforce Survey based on the practice's deprivation status shows those most in need have lower staffing levels.[20] Although properly completed survey returns were low (40%), within those limitations there were indications of an inverse care law for health care staff:

Estimated WTE/10,000 patients by practice deprivation

Quartile 1 = least deprived; **quintile 5** = most deprived



University of Glasgow - Research Institutes - Institute of Health & Wellbeing - Research - General Practice and Primary Care - The Scottish Deep End Project - Recent additions (January 2022)

General practice provides universal, local, comprehensive, holistic primary medical care – a powerful mitigation for health inequalities. Upstream measures, and especially the reduction of poverty, are of utmost importance and should be addressed, but also require major, costly societal and economic reform. With its low budget and proven cost-effectiveness, general practice is an ideal focus for change.

GP scarcity also brings potential loss of continuity, which provides better outcomes and is especially important in deprived settings, with relational continuity particularly preferred by those with poorer health status.[21] Such continuity is associated with lower mortality, fewer emergency hospital admissions, fewer condition-related complications, and higher patient satisfaction.

The over-riding reason for Scotland's poor health record relates to inequalities. It is therefore urgent that we support those working in deprived settings, not least as failing to do so is likely to result in an even bigger shortfall of GPs and other staff.

The GP Workforce

We know that Scottish GPs serving deprived populations are subject to multiple inverse care laws, with impacts on their wellbeing. They:

- are more stressed and manage more issues, but in shorter consultations,[22]
- are likely more at risk of burnout,[23]
- feel greater pressure from insufficient time,[24]
- experience significantly lower job satisfaction, lower positive, and higher negative job attributes, and higher job stressors whilst their patients were less satisfied with access and consultation quality,
- have patients who suffer digital poverty, and low literacy levels, making Deep End work more reliant on health care staff and conversations rather than online resource and self-help,
- tend to be older and work in smaller, and often single-handed practices,[25]
- deal with higher levels of co-existing physical and mental ill-health, care for patients with shorter lives lived in poorer health (early-onset multiple morbidities), lower health literacy, with patients reporting lower enablement scores and patients reporting higher burnout and stress,[26]
- have patients who perceive them as being less empathic than in more affluent communities.[27]

Qualitative research indicates that Deep End GPs face additional challenges in terms of the newly evolving consultation models.[28] Telephone consultations were described by some GPs in the study as the only way to cope with an already-unmanageable workload, allowing those needing less input to be managed quickly, but they can also increase workload intensity, on top of a rising volume. Telephone triage – a model likely to stay to some extent – can have increased risk in deprived populations, with potentially reduced access for the less able and risks being missed as well as opportunities to explore deeper problems. Patients may find these difficult to bring to the surface in a phone call, often from homes or workplaces affording little privacy. Poor health literacy, mental ill-health, requirements for interpreters all add to very significant concern. During the pandemic there was widespread, justifiable anxiety about missing cancer or other major pathology, whilst patients known to have long-term serious health problems, suddenly became 'invisible', not contacting the practice. These issues have also been considered by the Deep End,[29] findings confirmed by the third sector too.[30]

Many GPs in the study described moral injury – knowing that they were not able to address needs as they should. They described feeling anxious, burnt out and exhausted, although all felt that they had approaches they could use to manage these for now.

There were feelings of isolation and burden associated with heavy consultation workloads. However, the strongest theme is that there is simply not enough workforce to manage the demand, or more importantly, the need. We need to focus on both recruitment and retention and recognise that all the factors that apply to the workforce generally will be amplified in more deprived settings. We also need to improve data round both workforce and measures of complex workload (and not just number of patient contacts) if we are going to properly estimate the workforce requirement. Some of these pressures are outlined in RCGP Scotland's GP retention paper.[31]

The severe pressures in the UK are reflected in recent research, showing British GPs being the most stressed, and most likely to leave the profession, of ten countries surveyed.[32] However it also demonstrated that British general practice uses data more to inform its practice – and important for health inequalities – is well prepared for managing patients with complex needs. The central concern now is that we will further erode the workforce in Deep End practices as the work and workload pressures become even more overwhelming, or GPs no longer feel that they can work safely or without compromising their core values. That would be catastrophic for Scotland and needs urgent action at a national level.

The good news is that there is clear evidence that interventions can help, both in terms of patient outcomes as well as training, recruitment and retention of GPs. That was demonstrated by the Scottish Care Plus randomised controlled trial, which showed cost-effective improvements in patient wellbeing, but also enhanced GP retention.[33] Generally in Scotland, GP retention schemes are underutilised, and we need more and better, tailored to Deep End working. We need time and resource for reflective practice for those working in areas of highest deprivation. The Care Plus study included a core element supporting practitioner wellbeing. Reflective practice in such settings would recognise the disproportionate emotional labour of GPs working in deprived settings, and their higher levels of burnout and lower empathy scores. However, the ultimate intention should be to offer that to all GPs.

The Pioneer Scheme,[34] discussed further below, not only helped recruit younger GPs, but brought renewed optimism to practices, with some older doctors who had anticipated leaving, instead staying on. It improved practice capacity and patient care and identified four key themes for motivation and satisfaction: relatedness, autonomy, mastery and purpose,[35] which will chime with general practice more widely.

The risk is that as our GP workforce diminishes, fewer GPs will elect to work in deprived practices, as workloads and GP perceptions of unmet need (the latter profoundly demoralising) rise yet further. The Health Foundation, commenting on English data,[36] argues that with fewer GPs per patient and higher workloads in deprived areas, "there's a risk of perpetuating a cycle that could leave Primary Care Networks serving the most deprived populations (with the greatest health needs) the least able to recruit." They note that already the "number of FTE GPs is falling fastest in most deprived areas, but those are precisely the areas with the greatest health care need." There are therefore both public health and general practice viability arguments for stabilising and expanding workforce provision in the most socio-economically deprived primary care settings.

GP training

There is much that could be done to encourage more doctors into Deep End general practice, and to keep the invaluable experience of those already there. Such teams need to deliver so much more healthcare in practices themselves, as those who are marginalised find it difficult to engage with specialist and other care. When multimorbidity is the norm (including of severe psychosocial problems, drug and alcohol use, obesity, intersectional working and caring for vulnerable families), those in training need to spend more time in the community, as siloed secondary care services have less to offer in terms of useful experience for their future work. Another example is advocacy, rarely taught, and core to Julian Tudor Hart's approach, which protects against doctor burnout.

Health inequalities medicine should be part of all medical school curricula to reflect one of the dominant drivers of poor health outcomes in the UK. This is core NHS work, especially in Scotland, yet it is in some parts of England that curricular development is taking place.[37] This will require a greater emphasis on this area for all doctors in training, including GPs. However, we additionally need specific schemes focussing on health equity for those planning to work in areas of socio-economic disadvantage, recognising that the existing approach does not equip GPs for that role.

Medical students are more likely to be from affluent backgrounds, but some strategies to recruit differently do work.[38] Deprived practices will need additional support if they are to have medical students learning in them, and GPs at the Deep End has outlined the challenges, and what is needed to help bring those from deprived backgrounds into the medical workforce.[39] There is an inverse teaching and training law,[40] and Scottish data shows that training practices "were found to be significantly less deprived and significantly larger when compared with non-training practices" and are 50% under-represented in more deprived areas.[41] Practices in the least deprived quartile are substantially more likely to take on training status than those in the most deprived quartile. The authors showed that those training in deprived areas are subsequently more likely to work there, but "lack of experience in treating those affected by deprivation is itself a barrier to good quality care". The inclusion of those from socio-economically deprived backgrounds in the medical workforce is key and we note the success of the welcome REACH scheme.[42] Widening access is an area RCGP Scotland is interested in considering further.

Capacity can be the block to Deep End practices taking on trainees. A Scottish study examined in detail barriers and benefits to training in areas of deprivation,[43] with "overwhelming workload" found to be the single most important factor for a practice not to undertake training. Yet GP trainee surveys have shown keenness to work in areas of deprivation, and those that do so identify benefits, which fit closely with Scotland's public health needs.[44] The changes in training needed to reflect those priorities can also transform the learning environment for the better.

What is required is a systematic appraisal of Deep End training capacity with an assessment of barriers to training and detailed plans of how to address those. That might involve premises expansion, schemes to reduce workload, additional resource, and of course the building of relationships with potential and existing trainers. We need to consider how we can support trainers better. The focus on rural general practice has brought benefit, and that should be extended to deprived settings too. We are encouraged by the Scottish Government intention to create a Health Equity Focussed Training (HEFT) programme, with both GPs at the Deep End and RCGP Scotland involved in planning discussions. The impressive North Dublin GP training scheme provides a blueprint for how to equip GPs in training for the work that lies ahead, and we know that it has been extremely successful in recruiting.

In Scotland, the Scottish Pioneer scheme[45] is, disappointingly, no longer funded, despite excellent outcomes. It gave recently qualified GPs a chance to work in deprived practices, with support and protected time. It proved highly successful both for retaining the GPs undertaking the scheme, but also some more senior GPs in participating practices who had been considering leaving. We therefore welcome the Scottish Government proposal for a new Fairhealth Fellowship, incorporating some Pioneer elements, one of the recommendations of the Primary Care Health Inequalities Short-Life Working Group: report. Its loss aptly demonstrates Scotland's strong implementation gap relating to a failure to scale up success and policy short-termism.[2]

However, a similar approach has been adopted by England's Fairhealth Trailblazing scheme[46] with proposals to roll that out more widely in Health Education England's planned 'Health Equity Focused GP Training' programme. The scheme provides Fellowship, as well as GP training options, and talks about a "practical equity framework for primary care" - the sort of language we need to adopt. The Scottish Government has set its intentions to develop an ongoing Scottish programme, learning from both, which is very welcome.[47]

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RCGP SCOTLAND

RCGP Scotland represents a network of around 5,000 doctors in Scotland aiming to improve care for patients. We work to encourage and maintain the highest standard of general medical practice and act as the voice of GPs on resources, education, training, research and clinical standards.

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