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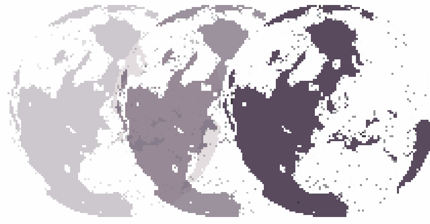

Submission of evidence to the Scottish Government's Health and Sport Committee enquiry

Out-of-hours health care provision in rural areas of Scotland

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Submission of evidence

Scottish Health and Sport Committee

Short inquiry into out-of-hours health care provision in rural areas of Scotland.

Questions

To inform the inquiry, the Committee is seeking views on the following questions:

- What do you think is the most sustainable and cost-effective way to provide adequate out-of-hours services in rural areas?
- What are your views on the quality of out-of-hours care provided in rural areas, in particular clinical safety and effectiveness?
- What are your views on the accessibility and availability of out-of-hours care in rural areas?
- How well do you think does NHS 24 and the Scottish Ambulance Service link in with existing out-of-hours services?

Context and principles

(1) It is important to have regard to the core principles of the NHS; namely, universal care, equal access for equal need and services provided free at the point of delivery. Cost is not a reason for departing from these principles. The whole point of public services is to distribute funds and resources on the basis of need by pooling the risks and costs of care across its communities so that those in rural areas, where unit costs may be higher, will not be denied care because of population sparseness and small numbers. This is the principle which underpins all public services. It is important to pay close attention to the mechanisms for funding, which enable risk pooling across the whole population in order to ensure that communities are not denied core entitlements to care.[1]

(2) The citizens of Scotland have had universal access to primary care since 1948 and the GP is both the gatekeeper to other care and the family/community physician. There is a strong evidence base to underpin the importance of this role, especially in vulnerable communities. The UK GP gatekeeper role and primary care system has become the model for many health systems across the world, based on its integration, continuity of care, cost efficiency and holistic approach to family and community-based medicine.

(3) The 2004 UK GP contract enabled health boards to contract out primary care, GP and other services to a range of alternative providers—including commercial providers—for the provision of GP out-of-hours (OOH) care.[2,3] This policy involves a radical change to the mechanisms for funding, allowing the break-up of risk pooling mechanisms. The justification for this was to increase efficiency and control costs through market competition.

(4) Until 2004 the majority of GPs provided OOH services directly or used GP cooperatives to provide services. Since 2004, the responsibility for providing OOH services now lies with Health Boards in Scotland.

(5) Some health boards are using the opportunity afforded by the new contract to withdraw GP OOH care from local communities, thereby removing what has been a core entitlement for citizens for 60 years. The effect will be to introduce unfairness and inequality of access and to deny local GP care to some groups of citizens—between 6.30 pm and 8 am, Monday to Friday, and all day on weekends and bank holidays—simply by virtue of where they live. In essence, for about two-thirds of the week patients no longer have continuity of care from their GP and are dependent on OOH services, some of which employ GPs or are run by GPs.

Quality of care

(6) Many of the alternative providers of OOH care (i.e., NHS 24, community pharmacists, the Scottish ambulance service) are—though highly skilled—neither medically qualified nor trained in the full range of clinical emergencies or treatment provision. They cannot substitute for GP care.

(7) Some health boards are also advocating the use of supplementary support from volunteers in the community under a system known as First Responders, for which the community may also have to pay. This has been both in addition to, or as a substitute for, GP services. Yet only a relatively small proportion of medical emergencies fall into the categories of care which First Responders can handle, and there is no evidence to support the service as an alternative to traditional GP cover.[4] There are, however, considerable opportunity costs for the NHS, for community volunteers and for the public in time and money foregone, none of which have been systematically evaluated.

(8) The evidence base for the cost-effectiveness, quality and safety of alternative systems and providers of care is not well-established, but some official evaluations raise concerns. In 2006, the National Audit Office reported that many OOH providers in England were not meeting national Quality Requirements for access and clinical assessment, and that poor data management made it difficult to fully monitor and enforce mandated quality standards.[5] An ongoing Care Quality Commission enquiry into OOH provider Take Care Now has found that nationwide monitoring of out-of-hours GP services may be inadequate.[6] In 2007, Audit Scotland also highlighted: 1) no coherent national approach for monitoring and enforcement of standards; 2) a lack of clear quality standards for OOH services; and 3) no routine monitoring of how OOH services impact locally on other aspects of the NHS.[7]

(9) Some 13% of the population are estimated to use OOH care[8], and the NAO found that one in five patients reported having a negative experience.[5] Research studies have also highlighted that many patients are confused by the new models and providers of care, unsure about whether and how to access it.[8]

(10) However, surveys of patient satisfaction with OOH care are not a proxy for data and information on access, quality, safety or coverage. Too often these are used as a substitute for adequate data on access by policy makers.

(11) Contracting out introduces new costs, but so far as we are aware these have not been estimated in the case of OOH services. However, evidence is available from other parts of the NHS, where alternative providers are being introduced. For example, Independent Sector Treatment Centres and the Private Finance Initiative in hospitals have demonstrated increased transaction costs as a result of commercial contracting. They are also associated with loss of efficiency and integration, deskilling of staff and lower quality of care; all of which have implications for safety and quality.[9,10,11]

Need for and access to care

(12) Research evidence has shown that the opening hours of general practices influence patients' healthcare seeking behaviour, and that lack of access may increase delay both in seeking treatment and obtaining assessment for certain conditions, such as minor strokes.[12] Delay in seeking care is also associated with increasing age.[13] People in remote and rural areas tend to be older[14], and already face substantial access barriers related to travel time, distance and lack of public transport; the removal of out-of-hours service will only increase barriers to care. People in rural areas are also more likely to delay in seeking care and to wait until they can see a GP.[15]

(13) A small population will generate low numbers of contacts and emergency contacts, but the need for care or the risk to that population is no less than elsewhere; indeed, the older age profile of populations in rural areas would suggest quite the contrary. One local medical committee in Tayside misinformed the public and the panel in their evidence on KLR by equating small numbers of people living in a rural area with low clinical need and low risk.[16]

Cost and efficiency and affordability

(14)The decision to remove services cannot be taken on cost grounds alone and is not a primary reason for departing from the core principles of the NHS and denying access to needed care. However, at least one health board, Tayside Health board, has tried to justify the removal of GP out-of-hours services on these grounds.

(15) The total cost of providing OOH care in Scotland was estimated at £67.68 million in 2005-6, but there has been no evaluations of the costs and benefits of the changes to OOH provision.

(16)Tayside health board has estimated the costs of restoring GP OOH service in one rural area, KLR at in excess of £500,000.[17] These figures postdate the decision to withdraw the GP OOH service in KLR and are an *ex post* rationale for denying care. The health paper on costs in KLR is an illustration of the additional transaction costs of breaking up GP services and introducing a market in alternative providers, thus departing from the principles of risk pooling and cross-subsidization and seeking to devolve the risks and costs to small communities through contracting mechanisms.

(17)In 2004, GPs were able to opt out of providing OOH care by forfeiting £6,000 per year per GP from their practice allocations. Tayside health board has not explained why in the case of KLR the cost of opting out from 24-hr care should be £12,000 (as there were 2 GPs who opted out), but that the cost of re-providing it should be in excess of half a million pounds. The NAO 2009 found that the amount of money that resulted from GP practices opting out of OOH care covered only 30% of the actual OOH costs in 2005-6, leaving a gap of 70%. Extrapolated to KLR, this would be at most £24,000 of additional funding at the level of the Scottish government or health board.

(18) Through the mechanisms of risk pooling, service planning and reintegration, it is possible to arrive at efficient and clinically effective local solutions for OOH GP services, as in the case of Applecross and other rural areas.

Service data and information for monitoring

(19) It is important to note that because rural areas are small and sparsely populated communities it will be difficult to monitor adverse events as a result of the denial of care, as deaths and poor outcomes will not reach statistical significance. Small numbers of people are not a reason for removing entitlements; to do so is to remove core entitlements from a particular group of citizens, undermining their rights to health care.

(20) We have undertaken a review of the core data available to monitor access, quality and outcomes of new services for out-of-hours care and shown that the data and systems to monitor access to health care and coverage for out-of-hours services are fragmented, not comprehensive or integrated, and that it is impossible to monitor access, quality, safety or outcomes of care.[18] This lack of consistent data besets ambulance service, NHS 24 and other alternative providers of care as well.

Key conclusions

(21) The decision to remove a universal entitlement to OOH GP services in remote and rural areas—or indeed any area—is ultimately one for the Minister and for Parliament, as it goes to the heart of the principles of the NHS. The removal of GP OOH services will introduce unevenness and unfairness in provision of core services and could create a new minimum standard which could be used as a justification for removing care in future.

(22) No evidence has yet been provided to support the changes and the introduction of alternative providers to GPs for OOH care.

(23) The provision of GP services has been both affordable and efficient for sixty years, and by paying close attention to the mechanisms for funding and planning, other health boards have and continue to provide OOH care through GPs.

(24) The claims about the rising cost of providing OOH GP services and the unsustainability of GP services need to be examined and subjected to scrutiny in the context of market transaction costs and the contribution that integrated services make to cost-effectiveness. For example, one of the

consequences of breaking the link between OOH care and individual general practices has been an increased rate of emergency admission, which has both cost and quality implications.[19]

(25) Health boards should not be able to remove core rights and entitlements from groups of the population without the assent of the Minister or Parliament, and without undergoing a proper consultation with the local community that shows what the implications of the alternatives are.

(26) In the case of KLR it is clear that public consultation was bypassed by virtue of a peculiar deficiency in the statute regarding the appeal mechanism for GPs and the panel. The community was denied the opportunity for a challenge, and this injustice has not been remedied.

(27) The Scottish government should consider reviewing the UK GP contract with a view to replacing it with Scotland-specific primary legislation, building on its programme of service reintegration, planning and risk pooling; this will enable it to preserve universal access to essential skilled GP OOH services.

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