Transforming Primary Care in Scotland: A critical policy analysis

Strong primary care is central to effective health systems, but both in the United Kingdom (UK) and internationally, primary care has proved one of the most challenging areas for health policy reform (1,2). Across the UK's four health systems, there are currently some strong resonances in policy ambitions, including broadening the multidisciplinary team to support general practitioners, encouraging place-based collaboration between practices, and innovating for quality improvement. However, especially when comparing England and Scotland, contrasting policy approaches to pursuing these goals reflect different governmental "styles of intervention" (3).

In Scotland, where health policy was devolved to the Scottish Parliament in 1999, primary care has undergone continual evolution as policymakers have sought to improve the quality of care delivered, and to address underlying - and still stubborn - population health inequalities. The seismic, top-down reorganisations that have characterised recent English health policy (4) have been absent in Scotland. There have, though, been significant developments. The wider health system was reconfigured by Scotland's 2014 Public Bodies (Joint Working) (Scotland) Act which mandated the statutory integration of health and social care, creating new integration authorities on a legal basis(5). Then in 2018, a Scotland-specific GP contract was introduced for the first time, removing the Quality and Outcomes Framework (QOF) from Scottish primary care.

Despite international interest, there remains relatively little peer-reviewed academic literature on Scottish health policy, as opposed to Scottish health services. One reason for this might be that Scottish reforms over the years of post-devolution health policy have been more incremental; lacking the 'big bang' system reorganisations we have seen in England (6). However, primary care in Scotland has been far from static: researchers have noted that the pace of layered reforms over the last decade complicates the potential to learn from and about specific policy interventions (7). We need new, and more nuanced conversations about how primary care in Scotland has changed, why, and to what ends. As a prompt for these conversations, we offer a critical summary of research on the Scottish reforms, contrasting the underlying approaches to reform taken by policymakers in Scotland and in England.

Scottish primary care reform: a summary
From performance management to quality improvement
From April 2004 until March 2016, the performance of primary care in Scotland was managed by the UK-wide Quality and Outcomes Framework (QOF), within the framework of a single General Medical Services contract used across the UK. The QOF allocated funding to GP practices for specific chronic disease-focused tasks as well as organisational management targets (8). In Scotland, the QOF was abandoned in April 2016 following protracted negotiations between the Scottish Government and the Scottish General Practitioner Committee of the British Medical Association on the first Scottish GP contract. This new GP contract aimed, among other things, to shift general practice away from an 'industrialised' biomedical, single-disease focused model of care towards a more holistic, values-based approach (8). A Memorandum of Understanding in 2021 acknowledged that agreed measures to achieve this shift – for example shifting responsibility for vaccinations from GPs to Health Boards – were not in place by April 2021 as planned (9). The very mode of policy communication here is

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notable: a carefully worded joint document, rather than competing statements looking to allocate blame.

GP clusters

'GP Clusters' are one mechanism for the focus on quality improvement. Encouraged to form across Scotland from early 2016, Clusters were then formalised as part of the new Scottish GP contract in April 2018. Groups of practices were encouraged to meet regularly, but given time "to develop at their own pace" (6), before national guidance was issued in 2019 (10). Clusters have a remit to plan and conduct quality improvement activities locally and engage in the local integration of care. They are thus intended to have both an intrinsic quality improvement function (within the group of practices in the cluster), and an extrinsic function (representing primary care within the wider local health and social care partnerships). Through the work of the clusters, primary care can in principle contribute to the aims of policy by adjusting clinical foci to local aims and needs - as opposed, for instance, to the 'one size fits all' approach incentivised by the QOF.

Research to-date has reported that clusters are up-and-running, being described by cluster quality leads as 'friendly' (11) and enabling sharing of understandings and experiences with colleagues (12). However, the same studies have identified a general lack of purposeful improvement activities within clusters, partly because of limited capacity for key tools including data analytics and quality improvement methods. In England, "flexible and enabling managerial support" (13) of collaborations has been found to support improved outcomes (14,15), but a "prescriptive, contractual" policy framework has been criticised for damaging existing collaborative initiatives (13). In Scotland, GP clusters have been relatively lightly managed by contrast, but the need for more capacity-building and training has been noted (11,12). Early concerns that clusters would struggle to deliver significant quality improvement without substantial support (16), remain pertinent. The ideal balance of central direction and local autonomy remains unclear, requiring further exploration, but local autonomy without resources to support improvement seems unlikely to succeed.

Workforce capacity and the multi-disciplinary team

A shifting role for GPs has been acknowledged to require significant investments in capacity to address workload (17). As well as plans to increase GP recruitment, Scottish policy has sought to build primary care capacity by expanding other roles in the multi-disciplinary team. This includes Advanced Nurse Practitioners, Allied Health Professionals and enhanced provision of Community Link Workers with these colleagues generally employed by Health Boards, rather than directly by practices (18). Research in one pilot area identified that the transition to multidisciplinary teams required significant investments of time from GPs in training and developing new team members (5). More broadly, an Audit Scotland review of primary care workforce planning was critical both of the pace of progress, and the lack of national data (18), and the chair of BMA Scotland's GP Committee stated the Scottish Government "urgently needs a credible plan" to remedy workforce shortages (19).

The Scottish Government pump-primed the planned changes by releasing monies to all Health Boards through a Primary Care Development Fund in April 2016. This provided over £30 million for local projects to test out new models of care. An independent evaluation identified some promising innovations, but was critical of what was described as a 'let a thousand flowers bloom' approach: over 200 small projects were funded for only short periods of time, limiting the generalisability and measurement of impact and sustainability (7).

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Proposed reforms in the National Care Service

Integration Authorities (known in most of Scotland as Integrated Joint Boards) currently commission most healthcare from the existing geographically-defined Health Boards. These, in turn, contract with local GP practices for provision of primary care. In response to a review of adult social care in Scotland (20), the Scottish Government has recently completed a consultation on potential primary legislation to support improved governance and accountability, and the implementation of the significant changes recommended in the review. These are expected to result in the development of a new National Care Service for Scotland within the next term of parliament (21). One proposal within this is that responsibility for contractual arrangements with GPs should shift from Health Boards to Integration Authorities. This potentially dramatic change has been strongly opposed by BMA Scotland as fragmenting "the close and interlinked relationship between primary and secondary care" (22), risking deleterious consequences for patient outcomes.

Comparing approaches to reform across the UK

The policy substance in Scotland shares some characteristics with recent primary care reforms in the other constituent parts of the United Kingdom. Primary Care Networks (PCNs) in England, groups of practices working with other community and voluntary services in their area, have similar goals (15). In Wales, GP clusters were formed as long ago as 2010 (23), although research suggests progress in driving change forward has been slow (24). In Northern Ireland, GP Federations have been established since 2016 (25). Collaboration, with other General Practitioners and with other health professionals in a multidisciplinary team, is a notable theme UK-wide (25). However, these reforms also showcase different "styles of intervention" (3), with Scottish policymakers often eschewing the 'control' levers recently favoured South of the border.

While a shortage of GPs is a challenge across all UK health systems (26), the approach to workforce issues in Scotland has been characterised as more collaborative than that south of the border. This has been attributed to the prominent role medical elites play within the smaller health policy community (27). In keeping with this generally cooperative approach, the Scottish Government's reforms to primary care have avoided unilateral top-down prescription and allowed significant local discretion (11). By contrast, PCNs in England have been accompanied by significant financial incentives making it difficult for practices to opt out, and Clinical Commissioning Groups have been tasked with ensuring all patients in their area are covered by a PCN (28). PCNs were created at remarkable pace, and research has suggested a "profound organisational fragility" (15) (likely related to this rapid genesis) and mis-matched priorities in policy objectives (including primary care 'voice' in the system, support for GPs, and place-based collaboration) (29). Recent proposals to augment the role of PCNs within a new NHS structure have been criticised for expecting too much too soon, potentially destabilising nascent collaborations (30).

The alternative approach in Scotland of reforming primary care through "incremental policy adjustment" (31) and with significant space for local discretion, is invariably slower. There are parallels with characterisations of a wider 'Scottish approach' to governance, associated with a "consultative and cooperative style" (32). The aspiration of gradual reform is that it yields more sustainable change, avoiding disruption and the risk of exacerbating the GP workforce crisis. Comparative research has found some of that crisis to be less pronounced in Scotland, with GP job satisfaction significantly higher in Scotland than in England in 2017/2018 (33). Nonetheless, there are trade-offs - and local discretion still requires national input and guidance to avoid reforms stalling. Some analyses have called for *greater* national support and guidance in Scotland, as primary

care transformation progresses patchily across the country (7,9,12). It is important that the often favourable comparison with English health policy does not prevent "critical analysis of the problems [the Scottish Government] faces and the ways in which it addresses them" (32).

Conclusion

General Practitioners' working conditions are shaped by the goals of primary care reform, *and* by the ways in which changes are decided and instituted by policymakers at the national level. There are enduring tensions in primary care policy between government control in pursuit of universality and fairness, and local freedom to develop services according to locally perceived need (2). While true of all health policy, primary care's history and structure in the UK renders this particularly acute. In Scotland, primary care reform has progressed gradually, and with significant scope for local discretion - sometimes to the frustration of those who wish for faster transformation. By contrast, primary care policy in England has been subject to repeated 'big bang' structural reorganisations, risking destabilising local collaborations.

These contrasting approaches to transformation in Scotland and England, as well as potential learning from Northern Irish and Welsh reforms, provide yet another example of the under-utilised insights available from examining the ongoing natural experiment in UK healthcare policy. Without action, this potential is likely once again to succumb to the dearth of comparative data sources. The Nuffield Trust has long called for better, more comparable performance data to be collected across the four NHS systems (34). Such national routine datasets would ideally allow direct comparisons of issues such as staffing levels, workload (including complexity of consultations), access, continuity of care, multimorbidity, polypharmacy, quality and safety indicators, and patient-reported outcomes. However, there seems to be little incentive to collect comparable data that will enable highly politicised comparisons. Across the UK, health systems face closely similar challenges of ageing, multimorbid populations, and a critical need to help address longstanding health inequalities. These challenges can also be found in many other health systems across the globe, where reforms towards high-quality care coincide with the aspiration to address health inequalities in the context of rapidly-ageing population (35). The ultimate test of Scottish reforms towards a collaborative and multi-disciplinary primary care will be in their longer-term outcomes. To assess these, we need richer and more rigorous comparisons both locally and globally to maximise potential learning for all.

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