Inequalities

Black infants have better survival odds in the care of black doctors though the reverse is not true; a doctor's race has little to no impact on the health of a white infant. Black babies' odds are not as good as their white brethren in any case but even noting that doctors vary for other reasons too — such as skill and experience — there is a clear systematic benefit from them being cared for by black doctors.[1]

It is tempting to seek solace from this being Florida we are talking about and not the UK. However recent examples of the disproportionate impact of COVID-19 infection on UK BAME healthcare staff[2] and patients[3] highlight what we already know; health inequalities are pervasive here too. Skin colour is not the only denominator of course. This has been unavoidable news at least since the publication of the Black Report in 1980.[4] Reducing inequalities is one of the requirements of primary care networks (PCNs)[5] though their access to public health expertise is minimal. The recent decision to abolish Public Health England in favour of a new organisation, the National Institute for Health Protection (NIHP) does not seem likely to help either. This one's focus has already been questioned as being likely to pay insufficient attention to health promotion.[6] Then there is the issue that new bodies take time to establish. The creation of PCNs is against the backdrop of a nadir in the primary care share of NHS funding and a pre-existing mismatch between deprivation and where primary care funding goes.[7] Channelling the new resources coming into primary care through PCNs leaves practices still in the tight spot they were in.

COVID-19 has not helped PCNs' development nor practices' resilience. Now, under renewed pressure to recruit, even if additional personnel can be found and have the desired effect of eventually relieving GP workload, at present, PCNs still probably represent a net drain on primary care capacity. Supporting CCG and PCN workloads while the overall number of GPs continues steadily to reduce, deepens the vicious cycle already affecting practices' resilience.[8] The law of supply and demand means locum prices are rising, encouraging more to give up practice commitments in favour of what is often now better pay and workload control. This further erodes the chances of patients gaining the personal continuity they value. Personal continuity matters; it has been shown to save lives.[9] GP distribution has been shown to be inversely associated with deprivation and sensitive to government policy, particularly funding.[10] Settled GPs in a place are a minimum condition for personal continuity.

Perhaps there is hope in medical schools taking on substantially increased numbers of students this year due to A level results being based on teachers' predictions rather than exam results. A recent survey confirms however that undergraduate exposure to primary care is still funded substantially below cost and that despite ambitions significantly to increase exposure, this is not currently happening.[11] Given the size of the new problem of how to teach consultation and examination skills in an environment where most patient contacts are being conducted remotely, it seems unlikely those ambitions will be realised soon. In which case, undergraduate teaching remains a net burden and an unreliable distant prospect in terms of adding to our future workforce.

So, primary care has a declining workforce and increasing pressure on its already poor finances, while future recruitment prospects remain very uncertain. Health inequalities are still very much here and despite our problems, we are meant to be part of the solution.

We need to be clear. Good primary care is, by its nature, integrated with its community: if the community is deprived, so is its primary care. The reverse is also true.

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