FINANCE COMMITTEE

DEMOGRAPHIC CHANGE AND AGEING POPULATION INQUIRY

SUBMISSION FROM BMA SCOTLAND

Background

1. The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 16,000 doctors.

General

What is your view of the effects of demographic change and an ageing population on the sustainability of funding for (a) health and social care and (b) housing services and (c) public pensions and the labour force? What public services will individuals increasingly call on and in what way?

2. The twin forces of an increase in longevity (driven by improving living conditions and medical innovation) and a decline in the birth rate over the last twenty years[1] have led and continue to lead to an increasingly elderly population. Medical innovation in particular has driven this demographic change, the largest contributor to the increase in life expectancy between 1990 and 2000 for example being an improvement in mortality from heart disease and stroke.[2] The interaction between demographic change and health and social care expenditure is complex.

3. The Scottish Government's strategy document, 'Reshaping Care for Older People', recognised that there will be 21% more people aged 75+ in Scotland by 2016, compared with 2006, and 83% more by 2031. Assuming demand increase in line with this growth and that current service models remain the same, it suggests this will require an average real increase in the NHS budget of 1.2% per year, every year. Local authority older people's social work budgets will also need to be increased significantly. An ageing population combined with a difficult public spending environment poses a very significant challenge, and we shared the concern that was expressed in 'Reshaping Care for Older People' that current arrangements were not sustainable.

4. If a sustainable and high quality NHS is to be maintained in the current financial climate then there will need to be an open and informed dialogue about the true cost of delivering health services and the priorities for the allocation of NHS resources. A decision will have to be taken on what the NHS can and cannot afford to deliver. This is not an intractable problem but one with potentially significant cost

[1] General Register Office for Scotland, Vital Events Reference Tables 2010, Births, *'Table 3.2.: Live births, numbers and percentages, by marital status of parents and type of registration, Scotland, 1974 to 2010'.*

[2] See: Does ageing really affect health expenditures? If so, why? Friedrich Breyer, Joan Costa-i-Font Stefan Felder. Accessed at: http://voxeu.org/index.php?q=node/6514

implications. How much we choose to spend on health care as Scotland's demographic profile changes is essentially a political decision and not a technocratic one. Doctors working on the ground both in primary and secondary care are ideally placed to help the NHS provide the services that patients need within allocated budgets. They are experts in delivering those services and must be engaged, both nationally and locally, in making key decisions on where efficiencies can be made with the least impact to the quality of care and patient safety.

5. The BMA recognises however that no matter how effectively services are organised and delivered, adequately resourcing quality health and social care for an ageing population will inevitably require significant extra resources. How these resources are made available, including the extent to which social care services are funded from the public purse is a matter for wider public debate, particularly given the current mixed economy of social care funding. To help them plan properly for the future, people need to know with some degree of certainty what care is going to be provided for them by the state should they need it, and what care they are going to have to fund for themselves, not just over the next few years, but over the medium and long term.

6. The changing demographic and ageing population is also having a direct effect on the NHS workforce. The UK Government is planning to bring forward a bill on public sector pension reform which will link the normal retirement age in the NHS pension scheme with the state retirement age – currently up to 68 but this is likely to rise in the future. This will see doctors and other health care workers, working longer into old age. Given the physically and mentally demanding nature of the work carried out in the NHS the BMA and other health trade unions have expressed concerns about how this will affect the NHS workforce in the future and their working patterns. Employers will have a responsibility to ensure that there are suitable measures put in place for end of career working arrangements so that those in their late 60s are not under the same physical or mental pressures as a much younger NHS worker. For example, a surgeon may not be as physically able to undertake a 5 or 6 hour surgical procedure at the age of 68. There are already precedents for front line staff in the public sector, such as the police, to have lower retirement ages because of the nature of their work. The proposed changes to public sector pensions has been met with fierce opposition from the BMA and resulted in the profession taking industrial action for the first time in almost 40 years. Our position on this change along with others to public sector pension scheme is detailed further in this response.

Further, what planning is being done, or should be done, to address this?

7. An ageing population combined with a difficult spending environment poses a very significant challenge for the provision of health and social care and there is a need to plan a co-ordinated system of community, hospital and residential health and social care to cope with a range of needs for an increasing number of older and very old patients.

8. There is an urgent and growing need to improve decision-making on what services are needed locally and how they can best be delivered.

9. Care of the elderly is one area in where secondary care doctors and GPs could work together to develop more effective and efficient patient care pathways. With demand increasing rapidly and resources already stretched there remains a great deal of room for improvement in terms of service integration across primary, community and secondary care and particularly between health and social care sectors. Different ways of working may result in aspects of health and social care being delivered by different parts of the service. It will be important to ensure that funding and resources reflect that.

10. While the BMA believes that putting doctors at the heart of clinical service development is crucial, we have no fixed views on how this is best achieved. Indeed, we are keen to avoid generating bureaucracy and additional costs through unnecessary organisational change. Now more than ever, the NHS needs to effectively harness the unique skills that doctors have, by enabling GPs and senior secondary care doctors to take a central role in planning and developing clinical services, and work collaboratively to deliver real benefit for patient care.

11. The BMA has long advocated a review of Community Health Partnerships (CHPs) and welcomed the commitment to replace these failing organisations with new Health and Social Care Partnerships and look forward to working with the Scottish Government to develop these models. It is vital, however that these organisation do not get bogged down in the bureaucracy and instead focus on patient care in local communities.

Health and social care

To what extent are preventative policies such as the Change Fund key to addressing demographic pressures on the provision of health and social care?

12. The Change Fund is viewed as providing "bridging finance to facilitate shifts in the balance of care from institutional to primary and community settings[3]". As the funding is bridging and not permanent it is difficult to envisage how it could ever be key in addressing the long-term demographic challenges.

13. The Change Fund provides limited, short term funding of developments in health and social care and whilst it can be used positively in service development it can only ever make a small impact on the massive demographic pressures faced. Additionally, the Change Fund focuses on the transfer of resources rather than considering the overall resource envelope.

To what extent are the pressures on health and social care a consequence of an ageing population as opposed to other health challenges such as obesity?

14. It is difficult to make reasonable comparisons between the pressures that an ageing population adds to health and social care with other health challenges such as obesity. Even if older people, as a whole, are living more healthily there are still added pressures to health and social care from the increasing multiple morbidities

[3] Scottish Government, '*Reshaping care for older people – Change Fund guidance 2012/13*', modified: 08.02.2012

and other health challenges that naturally come with age and it is difficult to separate the two.

15. In the article 'The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK'[4] there is discussion about the cost of obesity to the NHS in the UK. In 2006/7 over £5 billion was spent on overweight/obesity-related ill health although included in this is also costs from poor diet and inactivity as well.

16. The BMA would caution against making direct comparisons between pressures on health and social care from an ageing population and other health challenges. As with older age, obesity, alcohol, smoking etc are all linked to multiple morbidities this makes it very difficult to work out what the exact cost is to the NHS.

Pensions and labour force

What is the likely impact on the public finances within Scotland of demographic change on public sector pension schemes and what action is required by the Scottish Government and other public bodies to address this?

17. With predicted demographic changes and increased life expectancy the UK Government commissioned a review of public sector pension schemes. In March 2011, Lord Hutton published his proposals for the reform of public sector pensions across the UK. His recommendations were accepted in full by the Coalition Government. Under the current plans, the Government will increase employee pension contributions, replace final salary pension schemes with career average and link normal pension age with state pension age (currently up to 68 but this could rise in the future). As well as these planned changes, the UK Government replaced RPI indexation with CPI in April 2011.

18. In April 2012, the first tranche of increased contributions were applied to public sector workers earning more than £21,000 pa. Although a devolved matter for the Scottish Government, and despite opposition from the NHS trade unions, Ministers imposed the increased contribution to Scottish NHS staff.

19. The UK Government's main argument for its radical changes to the NHS pension scheme is that it is unaffordable and unsustainable. This does not stand up to scrutiny. In 2008, NHS staff agreed to major changes to their pension scheme to make it sustainable in the long term. This involved a large increase in employee contributions, and the introduction of tiered contributions to protect lower paid workers. It also meant an increase in the pension age for new entrants to 65, and employees – not taxpayers or the NHS – taking on the responsibility for any future rises in the cost of the scheme (for example because of increased longevity).

20. Clearly the country is now in a very different financial situation. However, this has not affected the sustainability of the NHS scheme. It is currently providing a positive cash flow of £2 billion (on average) to the Treasury each year[i] and a 2011

[4] Scarborough P, Bhatnagar P, Wickramasinghe KK *et al* The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006 -07 NHS costs *Journal of Public Health 2011;*33 (4):(527 – 535).

report from the Public Accounts Committee found that the 2008 reforms are bringing substantial savings to taxpayers, with the scheme set to be sustainable well into the future[ii].

21. With a move to a career average scheme, tiered contributions have little justification. Doctors will be paying some of the highest proportions of salary across the whole of the public sector. For example, doctors will have to pay up to 14.5% of their pay while a senior civil servant on a similar salary will pay 7.5%, to receive similar pensions.

22. The latest OBR Fiscal Sustainability Report shows that past service liabilities for (all) public sector pension schemes have reduced by £175 billion since March 2010[iii], mainly as a result of the change from RPI to CPI indexation. It is also estimated that the cost of public sector pension schemes has peaked[iv]. The BMA therefore does not agree that reform of the NHS pension scheme on grounds of affordability and sustainability, is necessary.

23. The BMA has opposed these changes as it believes they are not only unnecessary in terms of the NHS pension scheme, but that they are unfair. The BMA has even taken industrial action for the first time in nearly 40 years. Doctors are not looking for any special treatment or for better pensions; they simply want the BMA to be able to negotiate a fair deal. In July 2012, the BMA's UK Council took the decision to suspend further UK industrial action and to enter into talks with the other trade unions, NHS employers and the Department of Health on the England and Wales NHS pension changes. This includes representation on the working group which will look at the impact of an older working population.

24. In Scotland the NHS pension scheme is devolved to the Scottish Government, although pension policy is a reserved matter. While voicing its opposition to some of the reforms and the manner in which they are being imposed, Ministers have so far failed to come up with any genuine alternative and in April 2012, the Scottish Government imposed the increase to NHS staff contributions. It has however, established a working group with representation from the NHS trade unions, NHS employers and Scottish Government officials to discuss the pension changes in Scotland. Although correspondence between the Finance Secretary and the Treasury seems to indicate a limited scope for negotiation. The BMA is part of these discussions however it is essential that the Scottish Government clarifies exactly what it has the power to do in terms of negotiating a different arrangement in Scotland in order for progress to be made. The BMA will be considering the potential for further industrial action in Scotland.

[i] Office of Budget Responsibility – Fiscal Supplementary Table 1.5 – November 2010
[ii] Public Accounts Committee – 38th Report: the impact of the 2007-2008 changes to public sector pensions [May 2011]
[iii] Office for Budgetary Responsibility, Fiscal Sustainability Report, July 2012
[iv] Independent Public Service Pension Commission Report ('The Hutton Report), 2011