1. Are levels of health spending adequate?

The health portfolio remains protected in terms of its settlement within the draft budget and within this the revenue provision benefits at the expense of reduced capital spending. This means that in real terms revenue spending is forecast to grow at around 0.5% in 2013-14 and 0.7% in 2014-15. Historically this would be insufficient to meet demand pressures on the service. The NHS in general is subject to long term demand pressures of around 4 per cent per year over and above general inflation.¹ Some of these pressures arise from the additional needs of an ageing population whilst other pressures arise from technological advances and from excess inflation due to staffing accounting for a high proportion of the NHS cost profile.

If the planned increases are to meet these pressures, then the NHS in Scotland needs to reduce costs over and above background inflation, improve productivity such that increases in activity are absorbed at no additional cost or change the pattern of service delivery such that some demand pressures are eliminated at source. The draft budget commits to undertaking the third of these but this is a long term objective and not amenable to making up short term shortfalls in funding.

2. Are we spending wisely?

The priority areas identified for revenue spending are clearly appropriate but earmarking expenditure in a period of near zero real resource growth pre-empts health board priorities and should arguably be minimised where possible. It sits uncomfortably with the debate on priorities raised recently in the Scottish Parliament.

The lack of any increase in research funding may prove short-sighted since innovation will be one way of improving efficiency and productivity without resorting to crude cost-cutting.

The reduction in eHealth funding is concerning given that the Government is expecting IT integration between health and social care, likely through modified clinical portals. This will be costly and it is not clear if it will be achievable given the funding.

The Government policy priority of integration of adult health and social care is reflected in the budget. Evidence from the evaluation of the national Integrated Care Pilots in England has shown a number of benefits for staff, patients and service users that resulted from integration initiatives. These include:

¹ As measured by long term real expenditure
- More care plans and better co-ordination following hospital discharge;
- Staff enthusiasm about their pilot’s progress and its potential for future impact;
- Staff belief that patient care had improved over the previous year;
- Net reductions in overall secondary care costs for sites focusing on case management of elderly people at risk of hospital admission; and
- Reports of a wide range of local service improvements. However, the evaluation also pointed out that the most likely improvements following integrated care activities are in healthcare processes. Improvements are less likely to be apparent in patient experience or in reduced costs and are not likely to be obvious in the short term. It is also important to remember that certain groups have been identified as being most likely to benefit from integration, such as frail older people, people with multiple chronic and mental health illnesses and people with disabilities. Integrated care is not necessary for all forms of care and should be targeted at the patients and service users most likely to benefit.

Shifting the balance of care is the key part of the preventative approach adopted by Government. However, many of the services transferred from secondary care into community care are being absorbed by general practice and community services without funding or additional resource, such as staff time. There is a need to ensure that services moved into communities are established and funded to support this shift from hospital care.

While an increased proportion of patient assessment and care will be community-based, quality hospital-based health care will need to be maintained and developed for those who need it. No matter how well community-based services are planned and delivered, many patients will require hospital assessment and treatment. There is often an assumption that the only way to develop community services is to move funding from secondary to primary care, or health to social care, rather than considering the overall resource envelope and whether that needs to change.

Without adequate planning and investment for both sectors, Scottish Government’s aspirations to shift the balance of care and integrate adult health and social care may be unachievable and general practice could buckle under the strain of an impossible and unsustainable workload.

3. How are we ensuring that services are efficient?

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2 It should be noted that there was an unexpected increase in emergency admissions for patients who received an intervention. The evaluation makes the assumption that the reduction in overall secondary care costs balances the increased costs of emergency admissions, but this needs more work and is likely to vary considerably depending upon the types of integrating activities being pursued. The additional/new costs incurred from interventions were not included in the cost analysis.

3 RAND Europe and Ernst and Young LLP National Evaluation of the Department of Health’s Integrated Care Pilots March 2012

4 RAND Europe and Ernst and Young LLP National Evaluation of the Department of Health’s Integrated Care Pilots March 2012

The Health Committee, during its scrutiny of Health Board budgets identified the need for more detailed information to answer fundamental questions on how efficient services are. There is a lack of detailed information on how resources are spent and the outcomes that this funding delivers.

For example, the Scottish Government has made available the Change Fund to "[bridge] finance to facilitate shifts in the balance of care from institutional to primary and community settings". However, as the funding is bridging and not permanent it is difficult to envisage how it could be key in addressing the long-term demographic challenges. 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. SCVO has also raised concerns in its review of the Change Fund in year one that some money from the Change Fund has already been used to fill gaps in local authority funding. For example, the reported use of almost £1m of Glasgow’s £8m Change Fund share to buy in social care services from Cordia. There are also reports that Glasgow has ‘allocated’ substantial sums to purchase care home places.

It is also worth noting that while all services provided by the NHS are free at the point of access, some social care services are currently charged for on an individual basis. For this reason, we urge a clear distinction of social care services so there is clarity about which services will be provided by the NHS and to ensure that no funding is moved from the NHS into services provided by commercial and voluntary providers.

4. What are we doing to ensure that the quality of service regarding outcomes for patients is protected?

There is a need for a long term commitment to an evidence based approach in the drive towards an integrated health and social care service for the elderly. Both the NHS in Scotland and local government has entered a prolonged period of financial restraint and it will be a significant challenge to maintain the focus on quality and achieve concrete benefits for elderly people in such a difficult environment. Establishing new services or reshaping ones requires the right resources being made available at the right time.

5. How are we planning for change?

The single biggest challenge to health and social care services both now and in the long term is the increasing number of elderly people with multiple physical problems, cognitive impairment and increasingly complex care needs. BMA Scotland has consistently called for greater joint working between health and social care to address these issues. Projected future demand for elderly care services indicate that there will be 21% more people aged 75+ in Scotland by 2016, compared with 2006, and 83% more by 2031.

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Assuming demand increases in line with this growth and that current service models remain the same, this would require an average real increase in the NHS budget of 1.2% per year, every year. Healthcare spending is concentrated in the last year of life, but as people live longer, they are more likely to have more complex needs for both health and social care over extended periods.\(^8\) Local Authority older people’s social work budgets would also need to be increased significantly. An ageing population combined with a difficult public spending environment poses a very significant challenge, and we share the concern expressed in the Scottish Government’s report on “Reshaping Care for Older People” that current arrangements are simply not sustainable.

Other issues

Budgetary challenges
As a result of both general inflation and changes to the NHS pension scheme, the value of doctors’ contracts has continued to decline for the last five years. In real terms, this means a drop of 12% in earnings for consultants, 15% for GPs and around 7% for staff grade and 20% for junior doctors (registrars).

The UK government has stated that the two year public pay freeze will expire in April 2013 and there will instead be an expectation of a 1% average increase in rates. The Scottish Government has confirmed in a letter to the Doctors and Dentists Review Body earlier this month its intention that the public sector pay policy arrangements for 2013-14 would apply to NHS staff. This means a one per cent cap on the cost of the increase in basic pay for staff earning under £80,000 and a pay freeze for staff earning over £80,000. Whilst this cap will contribute to keeping cost pressures below background inflation, it is evident from the analysis undertaken by Professor Bell\(^9\) that other components of the resource budget have loomed larger recently given the reduction in NHS staffing allied to a pay freeze. These components might be more difficult for the Scottish Government to control. Improving productivity might also be difficult given that this depends to a considerable extent on a fully engaged workforce with high levels of morale and this is no longer to be taken for granted.

Conventionally, the GMS provision has been left static to reflect its dependence on any decision on contract uplift. For 2013-14, the BMA asked the Review Body to recommend the appropriate uplift and to do so such as to deliver a net income increase to contractor GPs of 1%. This will necessitate an overall uplift of at least 1.5% and this would need to be taken into account when looking at the impact of the overall settlement. However, writing to the DDRB earlier this month, the Scottish Government confirmed that, as for England, there was no need for the Review Body to make recommendations

\(^8\) “Funding health and social services for older people – a qualitative study of care recipients in the last year of life”, Hanratty B et al Journal of the Royal Society of Medicine, May 2012 www.ncbi.nlm.nih.gov/pmc/articles/PMC3360529/

on uplift for GMPs for 2013-14. The BMA is concerned about this decision by both UK and Scottish Governments to unilaterally change the remit of the Review Body. We believe that GPs should expect to be treated fairly and in line with other doctors in the NHS.

**Capital expenditure**

Whilst the profile for public expenditure primarily reflects the needs of the hospital building and renovation programme as well as the need to fund revenue expenditure, the movement of care from acute to non-acute settings itself requires investment if it is to provide long term savings allied to better provision. There is also a clear need to improve premises provision in existing general practices.

**Distinction awards**

The Budget sets out £23.5m for Distinction Awards (DA), a reduction of £0.5m from 2012-13. The DA system is currently under review and the independent DDRB report has been with Ministers since July 2012. Despite an FOI request, the BMA has been unable to persuade the government to publish this report which remains under consideration by Ministers. The BMA would welcome clarity on this issue and would appeal once again for this report to be published.

2012 again saw a particularly high number of retirals amongst consultants, both award-holding and non-award holding. Since awards were last granted in 2010 the number of distinction award holders has reduced by 24.4%. This reduction in award holders is now making it increasingly difficult for SACDA to perform the five-yearly review process as it relies heavily on award holders to carry out peer assessments. There are now significant numbers of specialties with no senior award holders.

**Public health medicine**

NHS Boards’ efforts to cut management costs are having a major impact on the availability of consultant in public health medicine posts for new CCT holders. It appears clear that, despite guidance to NHS boards on management savings providing for specific exclusions for senior posts involving a high clinical delivery element or requiring clinical expertise and knowledge for the effective functioning of the board, reducing management costs is having an increasing detrimental effect on the availability of CPHM posts across Scotland.

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