Scrutiny of the Draft Budget 2012-13 and Spending Review 2011

British Medical Association Scotland

The British Medical Association represents doctors from all branches of medicine throughout the UK. It is a registered trade union and professional association with around 70% of practising doctors in membership. The BMA in Scotland represents more than 15,000 doctors and is considered the voice of the medical profession.

Overview

It is clear that in the current financial climate, the Scottish Government faces some very difficult public spending decisions, and in this context we acknowledge its commitment to pass on, in full, the resource budget consequentials from any increase in health spending in England to NHSScotland. This in turn relates to the UK Government’s coalition agreement which guarantees that health spending in England will increase in real terms in each year of the UK Parliament. As the CPPR have already pointed out, while NHS resource spending in Scotland is projected to rise in line with inflation over the next three years, this is based on a GDP deflator forecast made in March, and inflation expectations for 2011-12 and 2012-13 are now higher, so further allocations may be required if this commitment is to be maintained. Although the spending review anticipates a roughly flat health resource budget in real terms over the next three years, it is clear that capital spending will continue to face severe cuts over the review period, notwithstanding the Scottish Government’s efforts to support capital spending through NPD and the HUB initiative.

Some commentators have mistaken the Scottish Government’s commitment on health resource spending for a commitment to insulate the NHS from the impact of the public spending squeeze. However, as the Scottish Government itself acknowledges in its draft budget document, factors such as Scotland’s ageing population, new technology and the cost of drugs mean that the NHS will in fact face severe budget pressures over the review period.

Efficiencies and priorities

As we emphasised in our evidence to the Independent Budget Review last year, there is a real danger that despite these budget pressures, efforts will be made to continue with the same policies, targets etc as previously, while spreading resources ever more thinly and hoping that efficiency measures and productivity gains will keep everything on track. The repeated rounds of efficiency targets that the NHS has already faced in recent years mean that areas where further savings can be made without impacting directly on patient services have become ever more limited, and it is unlikely that the NHS will be able to muddle through in this way. Decisive action needs to be taken to prioritise the core functions of the NHS and to maintain quality of care and patient safety, with an emphasis on services that are evidence-based and
provide value for money while maintaining clinical standards. Existing policy initiatives which take money away from clinical services, eg health board elections, should be urgently reviewed, and close scrutiny paid to the costs associated with the implementation of any new initiatives, eg the Patient Rights (Scotland) Act, in terms of opportunity cost and overall value for money.

Maintaining a sustainable and high quality NHS in the current financial climate will require an open and informed dialogue between politicians, the public, patients and health professionals about the true cost of delivering health services and a clear framework for making decisions involving priorities and the allocation of NHS resources. Doctors working on the ground in both primary and secondary care are ideally placed to help the NHS provide the services that patients need. They are expert in delivering those services, and both the Scottish Government nationally and NHS boards locally must engage with doctors and other professionals in making the key decisions on where efficiencies can be made, where cuts can be implemented with least impact and which services must be protected.

The dialogue around priorities must include discussion about the configuration of hospital services. Particularly in financially difficult times, NHS boards must be able to consider changes to the way they provide care, taking into account sustainability and clinical safety.

**Preventative spending**

We understand that the Health & Sport Committee’s scrutiny will focus on preventative spending. We support an approach to health spending that sees spending on long-term, evidence-based public health initiatives as an investment which could reap future dividends in terms of reducing health inequalities and improving health outcomes, and therefore help to avert future costs to the NHS. Such investments do not produce immediate returns and may well be vulnerable to budget cuts aimed at supporting clinical services in the short term; it is imperative that this does not happen. It must be recognised that preventative spending in the current budget round is unlikely to contribute to short-term reduction in expenditure.

The Financial Scrutiny Unit’s briefing on the draft budget notes that it does not include “an assessment under each portfolio heading of the progress being made towards a more preventative approach”, which was recommended by the Finance Committee in January this year. We believe this would be a positive step and would invite the Health & Sport Committee to consider this issue further.

In its draft budget document, the Scottish Government identifies the continuation of the Change Fund for older people’s services as one of the ways in which it aims to support preventative spending. We fully support moves to find sustainable ways of providing timely, high quality care to enable frail elderly patients to remain in their own homes as long as that is desired and appropriate, avoiding unplanned hospital admissions wherever possible.
This will require well coordinated and integrated stepped care, including end of life care, and quality community health and social care support available on a 24/7 basis. It will also require a well-trained and motivated workforce with adequate remuneration and a proper career structure. This all has significant resource implications, and the Scottish Government’s own strategy document, *Reshaping Care for Older People* suggests that if demand increases in line with the increase in the older population and existing service models remain the same, it will require an average real increase in the NHSScotland budget of 1.2% per year, every year, and significant increases in local authority social work budgets. In this context, and particularly given the ongoing squeeze on local authority budgets, we suggest that a Change Fund of £80m a year will do very little to move this agenda forward.

**NHS workforce**

A very high proportion of NHS spending is composed of workforce costs, and it is understandable that these should come under scrutiny as part of any review of public sector finances. But its workforce is also the NHS’s best asset, and well-trained, well motivated clinicians are vital to maintaining services and providing effective clinical leadership in difficult times. There is a common misconception that NHS workers have been somehow insulated from the effects of the economic downturn, and that workforce costs are a key area in which further significant savings can be made. This is absolutely not the case; our members’ terms and conditions have in fact come under repeated attack on a number of fronts over the last few years. Further attacks in this area will only serve to impact on the motivation and goodwill upon which the NHS relies.

**Pay freeze**

The Scottish public sector pay policy announced in November 2010 meant that pay was frozen for one year (zero percent basic award) for all NHS staff earning more than £21,000 from 2011. The Cabinet Secretary recently announced that this policy will continue for at least one further year from April 2012 (as previously also announced for England, Wales and Northern Ireland).

Doctors were already suffering from an erosion in the value of their pay in recent years with very low or zero pay uplifts not matching inflation and, in general practice, a failure adequately to recognise steadily increasing basic practice expenses. Major negotiations for doctors since 2000 resulted in modernised contracts and investment in doctors’ income. However, since the implementation of the contracts, doctors have consistently received below inflation/zero pay settlements and the investment in the new contracts has been considerably eroded resulting in real reductions in the value of basic pay and earnings. The table below shows the percentage value of contract investment for each group of doctor that will have been eroded between the implementation of the respective new contract and the anticipated end of the public sector pay freeze period in 2012/13:
Real basic pay contract erosion

<table>
<thead>
<tr>
<th></th>
<th>Since</th>
<th>Erosion of contract investment</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>2005/06</td>
<td>26.6 %</td>
</tr>
<tr>
<td>Consultant</td>
<td>2005/06</td>
<td>15.9 %</td>
</tr>
<tr>
<td>Specialty Doctor</td>
<td>2009/10</td>
<td>11.5 %</td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>2009/10</td>
<td>11.5 %</td>
</tr>
<tr>
<td>Junior Doctor</td>
<td>2000/01</td>
<td>10.9 %</td>
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*General Medical Services (GP) contract*

GP income has attracted a great deal of attention in the recent past. However, as outlined above, there has been significant erosion of the real value of GP contracts in recent years. Whilst GP contractors have not necessarily been expecting an increase in personal income, they do expect to be treated fairly and in line with other doctors and staff in the NHS. A pay freeze for GPs should mean that there is no change to net take home pay. However, failure to uplift the GMS contract to meet rising expenses results in a personal pay cut. Applying the review body’s formula for 2011/2012 indicated that an increase of around 1 per cent would be required to compensate GP contractors for increased expenses. The actual uplift to the GMS contract to cover expenses for 2011/2012 was 0.5%. This was targeted only on Quality and Outcomes (QOF) payments and required GPs to make other efficiency savings. GPs have therefore seen a further cut in pay.

To treat contractor GPs in the same way as their salaried colleagues, it is important that increases to gross incomes offset any expected increase in practice expenses. It is unfair to treat GPs differently to all other public sector workers by reducing their net incomes through subjecting their gross incomes to efficiency savings, or by requiring additional duties for the same remuneration.

If the double jeopardy of zero contract value uplifts and inadequate expenses uplifts is repeated in future years, the value of GP income will be even further eroded. It is worrying therefore to note the Scottish Government spending plan for zero increases to the GMS budget over the next three years. Eventually, the squeeze on GP funding will have an impact on the provision of services to patients.

In addition to the GP pay erosion caused by the above factors, some NHS Boards have been attempting to reduce GP income even further by applying additional efficiency savings to GP remuneration at local level. The BMA is extremely concerned about this recent development which is unfair and unacceptable.

If funding for primary care continues to fall, we will inevitably see restrictions on the services provided. This could in turn increase pressure on secondary care.
**Distinction awards**

This is another particular area of doctors' pay that has attracted recent attention. Distinction awards have been an integral part of the consultant remuneration package since the NHS was established in 1948 and recognise and reward outstanding professional work, especially that which shows wider benefit to the NHS. These awards were frozen for the 2011 awards round, resulting in budget savings for the Scottish Government, and the future position is uncertain until Ministers' response to the UK-wide review of awards schemes has been published. The planned cut in the draft budget document for spending on distinction awards in 2012-13 would therefore seem premature in the absence of any qualifying footnote.

**Pensions**

NHS pensions are coming under sustained attack. Firstly there are proposals to increase employee contribution rates by an average of 3.2% of salary over the next three years. For some of our members the increase will be as much as 6%, which would effectively mean an increase in contributions of 71%, far in excess of increases visited on other public sector groups whose existing contribution level is much lower. Changes to the NHS pension scheme were agreed back in 2007 to ensure its sustainability in the long term, and currently contributions to the scheme exceed benefits paid out by £2 billion a year. These latest increases are simply a tax on public sector workers, with the proceeds going direct to the UK Treasury. In addition, Lord Hutton's review of public sector pensions has proposed further fundamental changes which would mean our members working for much longer for much lower pensions.

It is clear that doctors have played their part in constraining NHS costs over the last five years through real terms cuts in their personal remuneration. Doctors have continued to provide high quality patient care, led improvements in NHS service delivery and worked with others at a local level to identify efficiency savings, while striving to keep Scotland at the forefront of medical research and practice. Repeated assaults on our members' terms and conditions cannot possibly be sustained without a significant risk of a major staff exodus, as highly skilled and experienced doctors, many of whom are eligible for voluntary early retirement, consider their futures.

**Summary**

Whilst the broader public sector financial environment must be recognised, it remains the case that the Scottish Government will have considerable difficulty in meeting its targets and aspirations for the NHS via its draft budget for 2012-13 and spending plans for 2013-14 and 2014-15. The repeated efficiency targets imposed on NHSScotland during previous and current years, the significant demand pressures of an ageing population and the need to maintain quality and patient safety, make this an extremely hard task. The Scottish Government should undertake an urgent review of what it can and cannot afford, focusing on core priorities and with an emphasis on services that are evidence-based and provide value for money while maintaining clinical standards. It should not and cannot plan on addressing the inadequacy of its budget by repeatedly seeking to worsen the terms and
conditions of service of NHS workers – that would be neither justifiable nor sustainable.

Gail Grant
Senior Public Affairs Officer
BMA Scotland
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1 http://www.cppr.ac.uk/media/media_212739_en.pdf
2 Improving Public Sector Efficiency, Audit Scotland, February 2010
3 Scottish Spending Review 2011 and Draft Budget 2012-3, Financial Scrutiny Unit Briefing, September 2011
4 Reshaping Care for Older People: A Programme for Change 2011-12, COSLA/Scottish Government, March 2011
5 BMA National Survey of GP Opinion, September 2011: confirmed that GP contractors expected decreases in their personal incomes and rises in expenses for 2010/2011, and that they expected similar effects on their personal incomes and expenses in 2011/2012.