The Correspondence and Enquiry Unit  
HM Treasury  
1 Horse Guards Road  
London  
SW1A 2HQ

22 September 2017

Dear Chancellor

2017 Autumn Budget Representation

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

The Association welcomes the opportunity to submit a representation ahead of the Autumn Budget 2017. Please find enclosed the BMA’s submission.

The BMA believes that a clinically and financially sustainable health service needs to be fully staffed by health professionals who are fairly remunerated, and motivated to help develop innovative service transformation. This needs to be supported by upfront investment, which will not just lead to a better and safer system for patients, it will also save money in the longer term.

Currently, as this submission sets out, the NHS is at breaking point. Funding is lagging behind demand, workforce shortages are rife; future staffing levels are at risk with many EU doctors planning to return home as a result of the UK’s decision to leave the EU; and England’s public health cuts are endangering the NHS’s future sustainability. This has even been recognised by the statutory regulator in its medical education and practice report last year.

Investment now can help reduce absenteeism, reduce litigation costs and tackle the system pressures identified following the Francis report that are posing a significant threat to patient safety – and which if not addressed will leave the NHS at risk of a future mid-Staffs style scandal. The BMA therefore calls for this Budget to address the following concerns

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1 Page two of the report for example refers to the ‘state of unease within the medical profession across the UK that risk affecting patients as well as doctors’. Page 4 goes on to say that ‘the evidence suggests pressure on staff is growing and this of course can have an impact on patient care.’
• The NHS is underfunded. We are calling for an increase in overall UK health spending to match that of the leading EU economies.

• The NHS is underdoctored. Training a doctor takes over 10 years and costs over £200,000, so it is important that we create a service that staff want to continue to train and work in. We call for fair remuneration for extra workload, especially to cover rota gaps and vacancies. We also ask that EU students and doctors continue to be allowed and encouraged to remain in education, training, work and research in the UK. To help doctors’ wellbeing, we are seeking additional investment in occupational health services for doctors.

• The pay cap and continuing decline in earnings create recruitment and retention issues. We call for the cap to be removed and for the real-terms pay cuts to be addressed. The independent Review Body on Doctors’ and Dentists’ Remuneration must not be constrained with an explicit public pay policy remit, and the government must implement the recommendations from this body.

• General practice is in crisis. We are asking that the UK Government commit 11% of England’s NHS budget to general practice – funding for this year is £3.7 billion short of that target.

• England’s mental health services are underfunded, and local authority public health functions face further cuts. Poor provision of these services ultimately costs more in terms of lost productivity and greater needs for acute healthcare.

• Increased taxation on tobacco and alcohol products above the rate of inflation, and stronger restraints on marketing for these and for unhealthy foods and drinks, will help address the problems of obesity, addiction, and the health and social conditions that arise. In addition, a particular area we would like to see action in is air pollution, which is a significant future cost threat to the health service.

As a membership organisation, the BMA has direct access to doctors across all parts of the health service, academia and in local government. We would be very pleased to facilitate more detailed discussions or events between government officials and ministers, and leading clinician members about the above issues. We have in place a programme of work across all the areas included in this representation. We appreciate the early engagement we have had with your staff on these and look forward to sharing the more detailed outputs of these over the next year.

We hope that our submission is useful – please do not hesitate to contact us for more information or to arrange a face-to-face session.

Yours sincerely

Dr Chaand Nagpaul
Chair of Council
Overall NHS funding

The UK is spending significantly less on health than other comparable European nations as a share of its GDP. Funding pressures are having a direct impact on the service the NHS is able to provide to patients.

In England:

- The government’s target to ensure at least 95% of patients are seen in A&E within four hours has not been met for 25 consecutive months, with the proportion of patients being seen in this time falling from an average of 96.6% in 2011/12 to under 90% so far this yearvi.
- The government’s target to carry out at least 92% of non-urgent operations within 18 weeks has not been met for 16 consecutive months, and the number of patients waiting for treatment has risen from an average of 2.5 million in 2011/12 to an average of 3.8 million so far this yearvii.
- The proportion of patients waiting two weeks or more for a GP appointment has risen from 12.8% in 2012 to 20% in 2017vii.

The BMA is therefore calling for an increase in overall UK health spending to match that of the leading European economies. Based on the most recent OECD data, this means that to match comparable countries the UK should have spent 10.4% of its GDP on health. In England this would mean spending £131 billion on health in 2017/18 rising to £143.1 billion in 2022/23. This means there is an effective funding gap of £7.3 billion this year (2017/18) and in five years’ time the NHS in England would be £14.6 billion better off compared to current levels of increasev.

As part of this, we would ask that secondary care is not pressured to make unachievable savings: the 2% efficiency factor set by the national tariff in England is unrealistic given the savings that have already been made, the average rate of improvement in productivity in the wider economy and the local deficits that already exist. At the end of 2016 the provider deficit in England was £791 million, higher than the predicted £508 million, and the Nuffield Trust has assessed the true underlying deficit to be closer to £3.7 billionvi.

In the immediate term, the NHS is facing a difficult winter ahead. NHS Providers has recently called for a short term injection of between £200 and £350 million to enable the NHS to manage patient safety risk this winter – we echo this callvii.

The 44 English local NHS transformation plans, which are meant to bring about innovative service change to deliver a clinically sustainable health service that will address these deficits, are not realistic. The BMA has estimated that around £9.5bn of additional capital spending will be required to fund Sustainability and Transformation Plans (STPs) for example. Along with other commentators like the Nuffield Trust and NHS Providers, we are very concerned that the Sustainability and Transformation Fund appears to have been used to plug provider deficits rather than the system change it was allocated for. The Vanguard scheme funding will also end next year, which we fear will lead to local areas being expected to develop new models of care but without new funding to make this possible.
Within the overall budget, we are also asking that governments address the current crisis in general practice, which has seen its share of funding decline steadily. The UK Government should commit 11% of England’s NHS budget to general practice to ensure quality and safety levels can be maintained. With nine out of ten GPs reporting that their workload is unmanageable these are currently at risk.5x

Unfortunately, the GP Forward View is currently not on track to deliver the full potential of its funding commitments. Although the pledge of a minimum funding uplift of £12 billion by 2020/21 through core recurrent funding appears to be on track, it is disappointing that so far little or no discernible progress has been made over the last year in leveraging additional investment from the rest of the system through clinical commissioning groups (CCGs) and sustainability and transformation funds. As a consequence, current investment falls £3.7 billion short of the BMA’s target of 11% of the NHS England budget. Furthermore, the proportion of the NHS England budget going to general practice, excluding the reimbursement of drugs, has actually fallen from 9.6% in 2005/06 to 7.9% in 2016/17.6x Ongoing underinvestment in general practice is having a damaging impact on quality and safety.

Failures within the social care system also impact negatively on an already stretched, overworked and underfunded NHS. Social care must be available free at the point of use for those that need it and current funding gaps need to be addressed. In England a social care funding gap of £2 billion has been predicted for 2017/18, rising to £4 billion by 2020/21.7x This needs to be filled, to avoid adding further pressures onto the NHS.

A disproportionately small amount of the NHS budget is spent on mental health (11% in England), despite the fact that mental health problems are the single largest source of burden of disease in the UK (23%).8x This is an issue because poor mental health carries an economic and social cost of £105 billion a year in England.9x People with a severe and prolonged mental health problem are also at risk of dying on average 15 to 20 years earlier than those without. To access psychological therapies, many patients have to wait over three months. There is also a lack of 24/7 access to care for those facing a mental health crisis (‘crisis care’). Due to many wards operating above their recommended occupancy rate of 85%,10x many patients have to travel far from their usual local network of services to access an acute bed.

Recent spending announcements in England are welcome, but it is important that these reach the front line to ensure the money invested is used effectively. Alongside this, greater investment towards the provision of crisis mental health care 7 days a week and 24 hours a day is needed and we want to see: an elimination of out of area placements; timely access to early intervention in psychosis services; comprehensive provision of evidence-based specialist perinatal mental health services; assessment and management of the physical health needs of people living with severe mental health problems; routine access to evidence-based psychological therapies for adults with anxiety and depression can access care; and comprehensive provision of child and adolescent mental health services.
Medical workforce

The NHS is facing a medical workforce crisis. The UK, with 1 doctor per 360 people, is under-doctored compared to the EU average, with 1 per 288. Workload for doctors has increased significantly with, for example, 28% more hospital admissions in England in 2015/16 than a decade earlier\textsuperscript{xiv}, and 16% more GP consultations in England in the seven years to 2014/15\textsuperscript{xv}.

The NHS is not recruiting enough doctors to sustain the service and cannot afford to lose more doctors. Fewer students are applying to study medicine in the UK. Statistics show that the total number of applications in 2017 is 15% lower than in 2013. Simply making more places available will not attract students into medicine. The government needs to create a health service in which doctors want to continue to train and work. The impact of Brexit has also seen a 17% decrease in EU applicants\textsuperscript{xvi}, to the lowest number since 2013, as well as a drop in applicants from non-EU countries. We are calling for sufficient stay for EEA medical students currently studying in the UK to allow them to complete their courses and continue on to foundation training, training posts and subsequent employment in the UK.

In England fewer doctors in training are progressing to become medical specialists. Only 50% of foundation trainees were progressing into specialty training in comparison to 64% in 2013. The number of doctor vacancies increased by 60%. Certain specialties and certain regions (particularly in the north of England) are struggling to fill vacant clinical posts including emergency medicine, acute medicine and psychiatry – but also some smaller specialties like allergy and endocrinology have meant patients in some areas have to travel significant distances to their nearest provider\textsuperscript{xvii}.

General practice is also facing a recruitment and retention crisis. Although posts and appointments are up, overall GP numbers are stagnant and the number of GPs working full time is decreasing. Recent research\textsuperscript{xviii} in England has shown that 2 in 5 GPs intend to quit in the next 5 years. It is not clear how the Government will meet its pledge of adding an additional 5,000 GPs to the workforce in England; it is unclear that plans to recruit from overseas will be successful with Brexit.

EU doctors and researchers currently working in the UK - on whom the NHS relies - should be given permanent residence to avoid further understaffing which may add to litigation costs further down the line. Any future immigration system must be flexible enough to meet the needs of the NHS and medical research sector.

The impact of this staffing shortage is felt in stress and morale, and ultimately in retention, as well as in the attractiveness of medicine to new or returning recruits. In England, many specialties have faced year on year shortfalls leading to junior doctor rota gaps and signalling difficulties staffing services down the line. Rota gaps increase staff workload pressures and stress, contribute to sleep deprivation, impact on doctors’ personal lives and relationships and affect patient safety/care. Three doctors out of five (61%) taking part in a BMA survey said their stress levels in the workplace had increased, with half saying they had felt unwell as a result of work-related stress over the past 12 months. This must be addressed to avoid both costly presenteesim as much as absenteeism.
It takes 10-15 years and an estimated £200,000 to train a doctor, which means that many current doctors will face an unmanageable workload for several more years, in order to cover these rota gaps and vacancies and the ever increasing demand. The BMA is calling on government to make medicine an attractive career choice once more, by fairly remunerating this additional workload which is often unpaid, and allowing doctors sufficient time within their working week for professional development, for teaching, research and to contribute to developing clinically and financial sustainable innovative solutions to the NHS’ problems. We are also calling for more investment and better access to occupational health services for all doctors (and psychological support for medical students) to help manage the levels of stress. Investment in these services now is an investment in the future and will reduce absenteeism, presenteeism and related costs such as litigation.

**Pay restraint**

Ending pay restraint for doctors is an important part of making the NHS attractive for doctors and to improve retention. Since 2005, doctors’ pay has decreased by 22%\textsuperscript{xx}, signalling the biggest fall in median real gross hourly earnings out of the ten pay review body occupations. We believe that doctors are being unfairly punished by government with continuing real loss of earnings and increasing cost pressures, when pay rises well above the public sector pay policy of 1% are regularly being seen across the economy. This has been recognised by employers themselves, with NHS Providers in England calling for a clear plan to end pay restraint.

Doctors are being asked to work longer and harder than ever to the detriment of their wellbeing, morale and motivation. As a result, more and more doctors are forced out of the profession and fewer people are choosing medicine as a career at a time when they are needed the most. This represents a poor return on the substantial investment in doctor training, as well as the risk it creates around the continuing ability of doctors and other health professionals to provide a safe and high quality service to an ever increasing demand from patients. It must be addressed by making the service itself a more attractive place to work, increasing productivity and morale, rather than through the introduction of a return to service agreement in England.

This is backed up by the independent Institute for Fiscal Studies (IFS) which has stated that further public pay restraint would take public pay to historically low levels relative to that in the private sector, and confirms that this would in turn make it harder to recruit, retain and motivate high quality staff. The IFS also notes that this is a particular issue for higher paid and better educated public sector workers which have fared worse than their peers in the private sector\textsuperscript{xx}.

We, therefore, call for the pay cap to be removed and for the real-terms loss of earnings to be addressed so the NHS can recruit and retain staff, increase productivity, ensure safe patient care and reverse the demoralizing effect of year-on-year pay cuts. As part of this, we ask that the independent pay review body, the Review Body on Doctors’ and Dentists’ Remuneration (DDRB), is not constrained with an explicit public pay policy remit, and that the government accepts and implements the recommendations from this body.
Public Health

Greater focus is needed on tackling the health risks of smoking, alcohol, poor diet and physical inactivity, which have been estimated to cost the NHS in excess of £18 billion per year in the UK.\textsuperscript{xvi} This will help reduce the increasing prevalence of long-term health conditions, and the associated pressures on the NHS and its staff, and should overall prove cost-effective and save money.

As smoking remains the leading cause of premature preventable death, a new tobacco control plan is needed in England, which includes provisions for increased taxation on tobacco products to 5% above the rate of inflation, mass media campaigns, adequate provision of quit smoking services, and a levy on tobacco companies to provide funding.\textsuperscript{xvii} The use of e-cigarettes should be regulated through a framework that maximises their harm reduction benefits and minimises any risks.

We ask that governments prioritise measures to reduce alcohol harm. Strong action is needed to tackle the availability, affordability and marketing of alcohol through increased taxation and reinstating the escalator at 2% above the rate of inflation, minimum unit pricing of no less than 50p per unit creating revenue for the Treasury, greater local powers on alcohol licensing, and a complete ban on alcohol marketing.\textsuperscript{xviii} We would like a new taxation band for still cider and perry below 7.5% abv (alcohol by volume), as anomalies in the excise system allow ciders of 7.5% abv to be taxed at the lowest price per unit of any drink. The ability to purchase high-strength alcohol for relatively low cost has significant consequences for health. The BMA welcomed the UK Government consultation on a new duty band of under 7.5% in March 2017. Now the consultation has closed, the Government should introduce this targeted and proportionate response – and align the cost of white cider to the costs it causes the Treasury further down the line.

While the 2016 childhood obesity strategy for England included welcome commitments to introduce a sugary drinks levy and a sugar reformulation programme, there is still a need for stronger restrictions on the advertising/marketing of unhealthy food and drink products to reduce the future cost burden of obesity on the health system. We strongly support the UK Government in taking the Soft Drinks Industry Levy forward, as a way of encouraging producers to reformulate their products to reduce the sugar content. This reflects our concern that the majority of children and young people consume too much added sugar, of which sugary drinks are an important source.

Air pollution is an area of public health which has the potential to create significant extra costs for the health service further down the line. We, therefore, ask that local authorities in England are provided with enough financial resource to implement the air quality plans they have been mandated to adopt by the end of 2018 in DEFRA’s new Air Quality Strategy. This requires additional funding beyond the current £295 million\textsuperscript{xxv} dedicated pot of funding for England as a whole, to ensure that local authorities are adequately resourced to deliver on their public health imperatives. To the extent that this is welcome news, it is still nowhere near enough for the task at hand. By comparison, Transport for London’s £875 million budget\textsuperscript{xxvi} allocated to improve air quality in London by 2021/2022 provides a much more robust illustration of the resource commitment required.
The BMA is extremely concerned at the cuts to the funding of local authorities in England for the provision of public health services and calls for these to be reversed, to ensure they can meet their obligations to improve the health of local populations and help reduce demand for health services and future costs. Recent analysis indicates that local authorities are planning to spend 5% less in real terms on public health in 2017/18 than they did in 2013/14;\textsuperscript{xxvi} for example, across England there are planned budget cuts to services which help people to stop smoking of 15% compared to last year and with sexual health services facing a cut of 5%. Both of these types of services have been independently proven to be cost-effective.

\textsuperscript{1} BMA (2017) \textit{NHS staff must be protected, says EU Brexit negotiator after BMA lobbying}
\textsuperscript{2} NHS England (2017) \textit{Monthly A&E Attendances and Emergency Admissions}
\textsuperscript{3} NHS England (2017) \textit{Consultant-led Referral to Treatment Waiting Times}
\textsuperscript{4} NHS England/Ipsos Mori (July 2017) \textit{GP Patient Survey}
\textsuperscript{5} British Medical Association (2017) \textit{What does the future hold for NHS funding?}
\textsuperscript{vi} Nuffield Trust (13 August 2017) \textit{The NHS deficit is here to stay}
\textsuperscript{vi} NHS Providers: (3 September 2017) \textit{Patient safety will be risked this winter without immediate funding and capacity boost for the NHS}
\textsuperscript{vi} British Medical Association (2 December 2016) \textit{Patient safety under threat from pressures in General Practice}
\textsuperscript{ix} BMA (20 September 2017) \textit{Investment in general practice in England}
\textsuperscript{x} The King’s Fund (2017) \textit{Adult social care spending}
\textsuperscript{xi} www.kingsfund.org.uk/projects/verdict/has-government-put-mental-health-equal-footing-physical-health
\textsuperscript{xii} Mental Health Foundation (2010) \textit{Economic burden of mental illness cannot be tackled without research investment.} Mental Health Foundation.
\textsuperscript{xiii} The Commission to review the provision of acute inpatient psychiatric care for adults (2015) \textit{Improving acute inpatient psychiatric care for adults in England.} The Commission to review the provision of acute inpatient psychiatric care for adults.
\textsuperscript{xiv} NHS Digital (2016) \textit{Hospital Admitted Patient Care Activity, 2015-16}
\textsuperscript{xv} The Lancet (2016) \textit{Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14}
\textsuperscript{xvi} British Medical Association (2017) \textit{The state of pre and post graduate medical recruitment in England, 2017}
\textsuperscript{xvii} British Medical Association (2017) \textit{The state of pre and post graduate medical recruitment in England, 2017}
\textsuperscript{xviii} BMJ Open (2017) ‘\textit{Quitting patient care and career break intentions among general practitioners in South West England: findings of a census survey of general practitioners’}
\textsuperscript{xix} Alex Bryson (UCL) and John Forth (NIESR) (2017) \textit{Wage growth in pay review body occupations. Report to the Office of Manpower Economics}
\textsuperscript{xx} Institute for Fiscal Studies (2017) \textit{Strong case for easing pay restraint of high skill public sector workers}

xiv British Medical Association (2015) *Promoting a tobacco-free society*.

xv British Medical Association (2017) *Tackling alcohol-related harm*.

