



Shaping the independence referendum debate for health in Scotland

Foreword



In less than two months, the people of Scotland will have the opportunity to vote in the referendum on Scottish Independence. Whilst the debate has focused largely on the big issues of the Scottish economy, our place in Europe and what our currency would be, there is a place for health in this debate.

Doctors, like the public, have questions about the future sustainability of the NHS, how we encourage doctors to come and live and work in Scotland, how we tackle poverty and subsequent health inequalities, how we can ensure access to higher education is based on academic achievement not ability to pay, and how we can ensure that Scotland's place as a world leader in medical research is maintained.

This paper, published in advance of a unique national health debate for the independence referendum, and hosted by the BMA, raises some of these questions. It is for each side of the campaign for and against independence to reflect on these important issues and to define how we as a country; either independent or as part of the UK, provide healthcare to the people of Scotland.

Whilst the BMA is keen to create a platform to encourage and facilitate debate on the issues surrounding health and the NHS in Scotland, we will not be adopting a position either for or against independence. There are widely divergent and deeply held personal views on independence among our membership and we do not believe it would be appropriate for us to suggest they vote one way or another on such a highly sensitive political matter.

However that is not to say that we do not think that health and the NHS has a place in this national debate. Health is devolved to the Scottish Parliament, but it will not be immune to the outcomes of the referendum – whether that is the status quo, independence or even a new, enhanced form of devolution.

The issues highlighted in our paper are priorities for the medical profession and should be priorities for all political parties. We hope that politicians on all sides of this referendum debate participate in helping to shape health policy for Scotland, whatever the outcome.

A handwritten signature in black ink, appearing to read 'B. Keighley', written in a cursive style.

Dr Brian Keighley
Chairman, BMA Scotland

Future delivery of NHS healthcare



Dr Brian Keighley, Chairman of the BMA in Scotland, recently warned that some tough decisions would be required around the future of the NHS. With an ageing population, living longer with multiple and complex care needs, how will you ensure that these decisions are taken in order to ensure sustainable healthcare for this and future generations?

Scotland's population is growing. By 2033 the population is expected to rise to 5.54 million. These population rises, along with increasing stocks of new housing communities across the country, will create increasing demand on existing health services.

Around two million people (40% of the Scottish population) have at least one long term condition.

The number of people aged over 75 will rise by 60% between 2004 and 2031. By the age of 65, nearly two-thirds of people will have developed a long term condition. Whilst 27% of people aged 75-84 have two or more long term conditions.

Long term conditions account for 80% of all GP consultations. The number of emergency hospital admissions for patients aged over 65 has steadily increased since 2003.



Can you confirm that you are committed to free healthcare at the point of delivery, and explain how you see this being funded in the context of economic constraint, above inflation growth in the costs of drugs, technologies and treatments, increasing expectation and demand, and challenges across Scotland in recruitment and retention.

The Scottish Budget is determined through use of the 'Barnett formula'. When the UK Government decides to alter spending in an area of devolved responsibility, such as health, the Scottish Government's budget is altered by a proportional amount. Such adjustments are commonly referred to as 'Barnett consequentials'. The Scottish Government is not required to allocate those Barnett consequentials to the area of spending from which they resulted, and can allocate any increased funds to any area of spending of its choice.

In the Spending Round 2013, the Westminster Government increased overall resource Departmental Expenditure Limits¹ (DEL) for Scotland from £25.6 billion in 2014-15 to £25.7 billion in 2015-16 in nominal or cash terms. Taking into account inflation, this was a real terms cut of 1.5 percent.

The NHS in general is subject to long term demand pressures of around 4% per year over and above general inflation. Some of these pressures arise from the additional needs of an ageing population whilst other pressures arise from technical advances and from excess inflation due to staff accounting for a high proportion of the NHS cost profile.

In order to meet these pressures the NHS will need to consider how it reduces costs over and above background inflation, whether that is by improving productivity which is absorbed at no additional cost; or by changing the pattern of service delivery such that some demand pressures are eliminated at source.

¹ Departmental Expenditure Limits (DEL) forms the majority of the Scottish Government's budget. This is the budget provision that the Scottish Government can plan and control over the Spending Review period. The DEL budget is presented for both resource DEL and capital DEL.

Medical workforce

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What more can be done to attract doctors to live and work in Scotland?

Successful workforce design requires both national and local solutions. At national level, greater flexibility in training and career paths is urgently required.

At local level, the challenge of attracting and retaining sufficient numbers of doctors with the right mix of skills is a priority issue to be addressed. This is particularly relevant where the healthcare service is relying on certain types of doctors, such as international medical graduates who may be declining as a proportion of the workforce.

However recent changes to immigration rules may help to remove barriers to international doctors looking to work in Scotland. As of August 2014, NHS Education for Scotland is now the Tier 2 sponsor for all medical trainees in Scotland. This means that medical trainees who are currently here under Tier 2 immigration status will no longer have to reapply for sponsorship at the beginning of each rotation.

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How can we ensure that Scotland remains a world leader in the provision of high quality medical training?

The medical workforce is a mobile one, both within the UK and further afield. For example, in 2010, 14% of doctors at the end of their Scottish foundation programme moved abroad, whilst 20% found jobs in other parts of the UK. Similarly doctors from elsewhere in the UK (and from across the world) will move to Scotland during their careers. With the structure of medical education and training the same across the UK, it is straightforward for doctors to transfer between UK health systems in particular.

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What can be done to improve the work/life balance for health professionals in the NHS?

Increasing demand for more complex, high quality healthcare is increasing pressure on the current NHS workforce. Doctors and other health professionals are working harder than ever to maintain services but asking more and more of the existing medical workforce will not resolve the problem for the long term. Stress and burnout is leading many doctors to choose to reduce their working hours, retire early or look for work further afield where the pressures are not so great.

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In recent years doctors have seen unwanted changes to their pay and conditions, how will these types of changes be determined in the future and what might they look like?

Pay

Traditionally, the pay of doctors has been determined by a UK-level independent review body (Doctors and Dentists Review Body). The BMA, the UK and devolved governments all submit evidence and the DDRB makes recommendations on the pay of doctors which each administration then decides whether to accept or not. This year, only the Scottish Government has accepted the DDRB's pay recommendation in full.

Pensions

In 2012, the UK Government announced changes to the NHS pension scheme which would increase doctors' contributions to as much as 14.5%. In the same year, the UK government announced changes to the taxation of pension savings which were introduced in April this year. The changes included a reduction in the Lifetime Allowance (LTA) from £1.5m to £1.25m.

Distinction Awards

The distinction awards process in Scotland has been frozen since 2010. This freeze was initially imposed as an interim measure pending the publication of the DDRB report into award schemes. There has been no increase in the value of awards, no new awards and no progression through the award scheme. Scotland is the only nation in the UK to freeze distinction awards (or their equivalent) and medical academics are telling us that it is affecting the recruitment and retention of international research talent to Scotland.

Public health and health inequalities



What can be done to address the social determinants that drive health inequalities and Scotland's reputation as "sick man of Europe"?

One in five of Scotland's children are officially recognised as living in poverty. In some communities this rises to one in three.

Poverty remains one of the most serious problems facing children today. Its' effects last a lifetime, negatively impacting on health, education, social and physical development and seriously harming future life chances and opportunities.

At birth life expectancy in Scotland was 76.6 years for males and 80.8 years for females but with considerable variation between areas. Male and female life expectancy was highest in East Dunbartonshire Council area and lowest in Glasgow City Council area. Males in East Dunbartonshire can expect to live for 80.1 years, 7.5 years longer than in Glasgow City (72.6 years). Females in East Dunbartonshire can expect to live for 83.4 years, 4.9 years longer than in Glasgow City (78.5 years).



Scotland has a strong track record for introducing world-leading public health policies. What assurances can you give that measures to improve the public health will remain at the forefront of Government policy?

Smoking

The adult (age 16 and over) smoking rate in Scotland is currently between a quarter and a fifth of the adult population. There has been a consistent trend of reduction over recent years, from 30.7% in 1999, to 22.9% in 2012. In terms of numbers of smokers, this means that just over one million (estimated at 1.01m) adults in Scotland continue to smoke. This too has reduced (from an estimate of around 1.16m adults in 2002), with reductions in smoking prevalence being partially offset by a continually rising adult population. Smoking remains higher in Scotland than the rest of the UK.

Alcohol

A significant proportion of the Scottish population consumes alcohol above recommended healthy amounts. Alcohol sales in Scotland in 2011 were equivalent to 21.6 units per person per week which is amongst the highest in Western Europe. In 2011 the alcohol-related death rate in Scotland was more

than twice the rate in 1982 and double the current rate in England and Wales. Alcohol related hospital admissions have more than quadrupled in the past few decades and Scotland now has one of the highest cirrhosis mortality rates in Western Europe.

Medical education and research



How can it be ensured that Scotland retains its reputation for excellence in the field of medical research?

Despite having only 0.1% of the world's population, Scottish research contributes 1.8% of the world's citations, and is ranked first in the world in terms of research impact per GDP. Scotland has several outstanding universities with particular strengths in the field of biomedical research, and this research in turn leads on to pharmaceutical, technological and intellectual advances. Its citation share is particularly high in biological sciences (2.4%) and medically-related research (1.8%).

Funding for UK research in universities, currently including Scotland, includes research grants from the seven Research Councils (<http://www.rcuk.ac.uk>). Each year the Research Councils invest around £3 billion in research, with awards made on the basis of quality rather than by country of origin. Scotland is currently successful beyond its population share - in 2012-13, Scotland was awarded nearly 15% (£257million) of the UK's research council funding for 8.4% of the population. The Medical Research Council alone awarded £766.9 million on research in 2012/13 on a UK basis, and in 2013, the MRC had eight large-scale research investments based across Scotland.



What assurances can be given that access to medical school will remain through academic merit and not ability to pay?

The duration of a medical degree is longer than the average undergraduate course, often five or six years. Medical schools also have longer term times than the average degree, leaving less opportunity for working outside of term time. In addition, medical students' outgoings are often higher than average due to expensive reference books, appropriate clothing for ward rounds, stethoscopes and other essential equipment, as well as travel to clinical placements. This leads to a higher average level of debt than those studying other courses.

It is vital that entry to medical school is based on aptitude rather than wealth. However, even without the introduction of tuition fees for Scottish domiciled students, a disproportionately high percentage of applicants to medical schools are from higher socio economic groups while lower socio-economic groups are less well represented.

Under the current arrangements for medical undergraduates:

- Students normally resident in Scotland or most of EU are not required to pay tuition fees for higher education;
- Students that are normally resident in the rest of the UK (RUK) are required to pay tuition fees, which are set independently by universities (up to a maximum of £9,000 pa);
- International students with no recourse to public funds pay up to £18,000 pa depending on the institution and course of study.

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