

Budget 2020: Representation by the British Medical Association

1. Introduction

- 1.1 The BMA (British Medical Association) is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding healthcare and a healthy population.
- 1.2 The NHS is currently experiencing unsustainable, unacceptable, and unsafe levels of pressure. As noted above, this winter has been the most difficult on record for the NHS, causing avoidable suffering and discomfort for many thousands of patients as well as further impacting on the morale of staff working hard to keep services afloat.
- 1.3 Key recent evidence of these pressures includes:¹
 - the proportion of people being admitted, transferred, or discharged from major A&E departments within four hours reached a 15-year low of 68.3% this December. This means that over a quarter of patients were not treated to the NHS Constitution 95% waiting time target.
 - An all-time record number of people waited over 4 hours (98,452 people) and 12 hours (2,347 people) on trolley beds for treatment in December.
 - there was little or no summer recovery in many parts of the NHS in 2019, with the four-hour wait target figures improving just 1.6% and 2% at all A&Es and major A&Es respectively – the smallest recoveries in 5 years.
 - only 84.4% of patients referred for specialist treatment were treated within 18 weeks, falling well below the 92% target, which has been missed every month since March 2016 - this is the worst monthly performance against this target since September 2008.
- 1.4 Although these figures focus on secondary care due to the availability of data, it is widely acknowledged that primary, community and social care services are also under severe strain.
- 1.5 These pressures are being made much worse by the Government's punitive pension tax rules, which have left many senior clinicians with no choice but to scale back their working time or face unfair large tax bills. The Budget is a key opportunity to put in place measures that can begin to turn this situation around. This submission sets out what the BMA believes is now needed to put the NHS back on a much more sustainable footing so that year-round pressures and severe winter crises cease to be the norm in our health services.
- 1.6 Due to health being a devolved matter the specific calls for investment set out below are England-focussed; however, many of issues addressed are just as pressing in the devolved nations. Therefore, we would expect to see any increases in health funding for the devolved nations through the Barnett formula to be targeted at similar areas to the ones identified below.

2. Overall health spending

- 2.1 The Government's current spending plans fall short of what is needed to place the NHS back on a sustainable footing and ensure patients receive the best care. The Institute for Fiscal

Studies (IFS) has estimated – based on the 2019 Conservative manifesto – that current government spending plans equate to a 3.1% annual real terms increase in total health spending – lower than the historic average and substantially short of the minimum 4.1% that the BMA, as well as the IFS and the Health Foundation, have called for². Even this 3.1% is not guaranteed in real terms, because the NHS Funding Bill only commits to cash increases and won't therefore take any fluctuations in inflation into account.

- 2.2 We estimate that the 'gap' in required funding by 2023/24 will be £6.2bn unless additional funding is announced. This doesn't take into account the fact that for the last ten years the NHS has been coping with funding increases well below the historic average. The NAO has recently issued a report on the sustainability of Trusts and have detailed that £10.9 bn in outstanding debt had been issued in March 2019 by the Department of Health & Social Care to trusts in financial difficulty³. The BMA estimates that had annual spending increases on health been maintained at 4.1% over the last ten years, the NHS would be £35bn better off today. The UK is likely to remain behind most other comparable European countries when it comes to health spending⁴.
- 2.3 Although the Government has set out its long term plans for NHS England revenue spending in the NHS Funding Bill, this provides an incomplete picture of overall health spending for the duration of this Parliament. This means there is uncertainty about the future of spending on NHS estates, IT infrastructure, public health and education and training. Without urgent and sustained investment in these areas the NHS's Long Term Plan will not be deliverable.
- 2.4 **We urge the Government to use this Budget to announce comprehensive plans for total health spending that will increase the Department of Health and Social Care's Total Departmental Expenditure Limit (TDEL) by 4.1% per year in real terms.**

3. Pensions

- 3.1 The current annual allowance rules and the separate changes introduced in the 2015 scheme have had severe unintended consequences on doctors and the NHS. As a result of the ill-conceived pensions taxation system, doctors are forced to stop doing overtime, reduce their working hours or retire early, in order to avoid unexpected and punitive charges on their pensions growth. Despite repeated warnings by the BMA, the reform of the punitive and unfair system of pension taxation has not happened and the impact of this on the ongoing workforce crisis has been catastrophic; 31% of doctors, surveyed by the BMA, have already reduced the number of hours spent caring for patients because of actual or potential pension taxation charges and 37% of doctors who have not already reduced their hours plan to do so in the next 12 months⁵. Consequently, waiting time for cancer and routine care are the longest on record and A&E performance the worst since records began.
- 3.2 **The BMA firmly believes that the only long-term solution is to remove the annual allowance (and thereby the tapered annual allowance) completely in defined benefit schemes such as the NHS Pension Scheme.** Due to the unsuitability of the annual allowance in defined benefit schemes, many perverse scenarios can occur. Indeed, a very small increase in pensionable pay can trigger large 'theoretical' pension growth that exceeds the standard annual allowance. If this pay rise is temporary, the situation is compounded as this tax is paid on theoretical pension growth that the doctor may never receive. We firmly believe

that the only solution to this complex issue is to scrap the annual allowance in defined benefit schemes such as the NHS. This view is shared by the Office for Tax Simplification (OTS), who have acknowledged that the 'rules are complex and widely misunderstood'⁶. They commented that it was unnecessary to apply both the lifetime allowance and the annual allowance on pensions savings, and went on to suggest that annual allowance should only apply in relation to the defined contribution schemes and the lifetime allowance in relation to defined benefit schemes. Raising the threshold income does nothing to avoid many of the problems caused as a result of exceeding the standard annual allowance, for example at the time of a promotion or a pensionable pay rise and not only does the tax cliff remain but it potentially makes becomes more precipitous. The Institute of Fiscal Studies agree with the BMA that this will not be an effective solution⁷.

- 3.3 Scrapping the annual allowance in public sector defined benefit schemes and scrapping the lifetime allowance in defined contribution schemes is not only the fairest and most effective solution for the NHS and the taxpayer but it is the most cost-effective solution for the Government. Initial modelling shows this option is cheaper than the alternatives of either removing the taper across all schemes or increasing the annual allowance threshold. Indeed, without meaningful long-term reform, the costs of re-provisioning clinical activity in the NHS will far exceed any receipts HM Treasury receive from annual allowance tax charges. Our proposed solution safeguards against future inflation, therefore ensuring that this situation will not be repeated as wages rise through inflation over the coming years. Most importantly, it completely solves the issue within the public sector and will allow NHS staff to do the work that patients need without the fear of large and unfair unexpected tax bills and supports the Government commitment to meet its manifesto commitments for the NHS⁸.

Ineffective Taxes

- 3.4 When it comes to defined benefits schemes the annual allowance and taper are not effective taxes for HM Treasury, as tax receipts from the annual allowance will start to fall as more people understand the issues or are afraid they may impact upon them. In addition, the lost income tax receipts from reduced work and the costs to the NHS from re-provisioning services from the private sector will far outweigh any revenue generated from these taxes. The latest available government figures for the 2017-18 tax year, suggest that the total value of pension contributions exceeding the annual allowance reported from self assessment was £812 million⁹. This would generate tax receipts in the region of £365 million if taxed at the highest rate of 45% across all sectors. This amount will be dwarfed by the cost of re-providing NHS services via the private sector, including the increased use of locums, and lost income tax receipts as doctors reduce the work they do for the NHS.

4. Pay and contracts

- 4.1 Since the start of the last recession in 2008, doctors have experienced a prolonged period of pay freeze and cap, at a time when inflation has run much higher¹⁰. As a result, our members have experienced the largest drop in earnings of all professions subject to a pay review body, with some groups having seen their pay fall by up to 30%. Further financial changes, such as the huge additional tax bills generated by the Annual Allowance and the high rate of pension contributions, the reduction in CEA (clinical excellence awards), the increased cost of training, and the rise of indemnity fees, deepen the impact on doctor's remuneration.

- 4.2 At the same time, doctors are being asked to work longer and harder than ever to cope with the ever-increasing demand, which ultimately affects their wellbeing, morale and motivation. Increased tiredness can also have a detrimental impact on patient care, and can, along with other factors, cause doctors to retire early or leave the profession altogether. Retaining doctors in the workforce must be a top priority for the Government to ensure the NHS provides safely staffed services.
- 4.3 **We therefore ask for the pay of all doctors to be uplifted at least in line with inflation and to explore a mechanism to address the real terms cuts in doctors' pay over the long run.** Unless meaningful steps are taken towards this direction, the resultant negative implications on doctors' morale and wellbeing will only exacerbate, further impeding the ability of the NHS to recruit and retain adequate and safe levels of staff. We also ask to ensure that DHSC has sufficient funds available for the forthcoming SAS contract negotiations (including awarding the 1% in SAS pay as per DDRB' recommendation that was ignored last year) and ongoing contract maintenance and improvements for all branches of practice.

Shared Parental Leave and tackling the gender pay gap in medicine

- 4.4 The BMA welcomed the enhancement to Shared Parental Leave for junior doctors in 2019, which saw it increased to the same levels as occupational maternity and adoption pay. We now ask Government to extend this offer to SAS doctors, GPs and consultants. Supporting all doctors to balance their home and work life in this way is not just the right thing to do, it will also help address the workforce crisis, avoiding expensively trained doctors dropping out of the workforce. Addressing this will incur a minimal cost to the NHS but could go a long way towards making the NHS a place where doctors want to work and want to continue to work.
- 4.5 Alongside this we urge the government to increase provision of NHS nurseries and other support for child care including access for doctors working in primary care to accommodate out of hours and shift working. Measures such as these should form part of a broad strategy to tackle the gender pay in medicine, informed by the findings of the Gender Pay Gap in Medicine Review due to be published later this month.

5. Capital expenditure

- 5.1 All across the NHS there are areas in dire need of capital investment following years of underfunding. Current bed capacity in hospitals in England for example is significantly short of what is needed to maintain safe and efficient services, as shown by our research revealing the continued use of thousands of 'escalation beds' outside of exceptional circumstances.¹¹ NHS England's Operational Planning and Contracting Guidance for 2020/21, published in January, asks NHS Trusts to increase bed numbers to return to meeting the 92% bed occupancy standard – acknowledging that there is a need to reverse the sustained decline in bed numbers in recent years.
- 5.2 The government's 2019 announcement of additional capital expenditure was a step in the right direction to address this. However, we believe **the Government needs to be more ambitious in its capital expenditure plans for the NHS in this budget by setting out a multi-year settlement. The UK should, at a minimum, match the health capital spending of other**

developed countries. Following years of underfunding the shortfall in capital funding in health is now so substantial that, for example in England, just to bring the capital budget of the NHS in line with the OECD average would require the NHS England capital budget to be increased from £5.9bn in 2019/20 to £10.3bn in 2023/24.¹²

- 5.3 NHS England has set out ambitious goals for local health and care systems, both in the Long Term Plan and in January's planning guidance. In order for these goals to be met and for models of integration to be successful, sufficient capital funding must be made available to support local plans.
- 5.4 There are three areas in particular where increased capital expenditure is urgently required: capital expenditure set aside to address the NHS's maintenance backlog; capital investment to ensure GP premises are safe and fit for the future; and much needed investment in IT infrastructure.

NHS maintenance backlog

- 5.5 The consistent underfunding of health capital budgets has been compounded by the short-sighted decision to permit capital to revenue transfers across a number of years to compensate for shortfalls in revenue funding for the NHS. These transfers have masked the true state of NHS finances at the cost of much-needed capital investment. Therefore, we are pleased that no capital to revenue transfers are planned for 2020/21. The Government needs to safeguard and increase revenue funding to ensure these transfers never take place again.
- 5.6 The impact of these transfers can now be seen in the maintenance backlog of NHS trusts. In England alone, the NAO (national audit office) has reported that this backlog now stands at over £6.5bn, of which over £1bn is required to address high risk backlog to prevent 'catastrophic failure or disruption to clinical services', and a further £2bn to address significant risk backlog.¹³ In a recent BMA survey, half of doctors stated the estates they currently work in are not fit to provide high-quality patient care.¹⁴ The extent of the issue was also recently illustrated by the threat from chief fire officers to multiple trusts that they would have to close hospital wards if they could not make necessary maintenance improvements to bring them in-line with safety requirements.¹⁵ This situation is not sustainable, and it is imperative additional capital funding is provided to trusts with the specific purpose of clearing the maintenance backlog.
- 5.7 **At a bare minimum, £3 billion of additional capital funding must be provided to trusts in 2020/21 with the explicit purpose of addressing the high and significant risk maintenance backlog.** It is unacceptable that the health and safety of patients and staff is being put at risk due to the inadequacy of the buildings in which they are treated and work.

GP premises

- 5.8 The neglect of estates also extends to GP premises, with a recent BMA survey revealing that half of GP practice buildings are not fit for purpose, and only two in every ten practices were fit for the future.¹⁶ The prolonged underinvestment in GP premises (including the inability of the NHS to spend previous ringfenced funding, which was lost back to the Treasury) threatens the delivery of general practice services. This needs to be urgently rectified to ensure GP practices are fit for purpose.

5.9 The government has committed to delivering an additional 26,000 staff members, as well as 6,000 GPs, and 50,000 nurses. Without additional capital investment in primary care, these pledges will not be realised. As part of increasing investment in primary care at a faster rate than overall NHS funding (as outlined in the Long Term Plan) the BMA is calling for an additional £1bn investment in GP premises, IT and practice infrastructure by 2023/24.

IT infrastructure

5.10 The BMA welcomes the enthusiasm the current Secretary of State has for radically improving IT infrastructure across all parts of the NHS, which is long-overdue an overhaul. However, before pursuing pioneering IT projects the priority must be to invest in the basic IT infrastructure that doctors and other staff groups use every day. Currently 32% of doctors say they do not have the necessary IT equipment and systems to perform their job to the best of their abilities without disruption.¹⁷

5.11 The inadequacy of the systems that doctors have to use was highlighted in a recent BMA survey, in which 27% of doctors estimated they lose more than four hours a week because of inefficient hardware systems.¹⁸ If this is extrapolated across all doctors working within the NHS in the UK, then we are losing millions of working hours a year from the current doctor workforce. Investing in better IT infrastructure is therefore an essential part of addressing the current NHS workforce crisis.

5.12 **The BMA recommends an immediate scoping exercise is undertaken across primary and secondary care to estimate the capital investment required to bring IT infrastructure up to standard, with subsequent capital funding being released in 2020/21 to meet this estimate.** Funding for IT infrastructure must be ring-fenced to prevent commissioners and providers from diverting funding for digital transformation to address short-term concerns. Any upgrade in NHS IT infrastructure needs to occur concurrently across primary and secondary care settings to enable interoperability.

6. Public Health

6.1 Since the 2015 Spending Review, the public health grant was subject to severe funding cuts, which by 2020/21 are estimated to amount to a £1 billion real-terms cut relative to 2015/16 levels.¹⁹ The need for a reinvigorated public health sector in the UK has become increasingly evident of late, with life expectancy improvements slowing dramatically and health inequalities widening. In order to deliver the ambitions of the Government's Green Paper on prevention and the NHS Long Term Plan substantial investment in public health is needed.

6.2 While we welcomed the recent announcement that the local government settlement would increase by 4.4% in real-terms, including a specific real-terms increase for public health, it is important that this reaches the level the sector has set out is needed.²⁰ **The BMA supports the Health Foundation and King's Fund call for the recent funding cuts to be reversed in full, to provide the £1 billion extra that is needed in 2020/21 and the additional £4.5 billion that is needed by 2023/24.** This will provide a vital boost to their ability to deliver services. For example, the BMA's forthcoming briefing on child health services in England highlights the impact of cuts to children's social care, sure start centres, public health services for 5-19

year olds and health visitor and school nursing numbers, and called for these cuts to be reversed.

7. Mental health

- 7.1 The recent funding commitments for mental health which have seen the total allocation of CCG (clinical commissioning group) spending on mental health increase to 13.8% in 2018/19 is welcome. However, this does not go far enough in reversing the historical underinvestment in mental health compared to physical health services. In the BMA's recent survey of healthcare professionals working in mental health 56% strongly disagreed that there was parity of resource between physical and mental health.²¹ **We are calling for adequate funding to be made available to CCGs to allow them to double mental health spending over the period of the Long-Term Plan, alongside increased investment in primary care, public mental health, mental health research and the mental health estate.**

8. Education, training and workforce

- 8.1 **If the NHS is to have any chance of resolving its workforce crisis then it is critical that the budget of Health Education England (HEE) is also increased, to guarantee that doctors have the necessary support throughout their training and working career to help them realise their full potential and stay in post.** In recent years, doctors have often found this support to be lacking. This has only been exacerbated by the cuts to HEE funding over recent years that have seen its budget fall from around £5.3bn in 2013/14 to £4.2bn in 2019/20.²²
- 8.2 An increased budget for HEE is required to support doctor's development and to help ensure that investment in the training of doctors is not lost through doctors leaving. Examples of the support required include: for SAS (staff, associate specialist and specialty) doctor's educational needs; increasing the overall value of junior doctor study funding to enable them to maximise their learning opportunities; expanding HEE's supported return to training programme to meet the unmet need for this support within the NHS's increasingly diverse workforce and increase the programme's accessibility; funding to support junior doctors with the personal financial costs they incur through pursuing their training; funding to ensure sufficient levels of educational supervision; fully supporting the workforce planning, development and retention priorities outlined in the forthcoming NHS People Plan.
- 8.3 Furthermore, NHS trusts and HEE need to be provided with adequate funding to ensure there are sufficient employment and training opportunities for all the medical students who are due to qualify through the expanded medical school places. It will be unacceptable if, after so much has been invested in the training of these doctors and at a time of severe workforce crisis in the NHS, we are left with medical unemployment as a result of trusts being unable to employ the doctors we so desperately need.
- 8.4 Retaining doctors in the workforce must be a top priority for the Government and it is therefore imperative that sufficient funding is provided for the workforce planning, development and retention priorities outlined in the forthcoming NHS People Plan. Doctors are increasingly taking career breaks, retiring early or leaving the profession altogether because they are burned out and have diminished morale and motivation. This is leading to rota gaps and unsafe staffing levels in many services.

9. Social Care

- 9.1 There is now a growing consensus among stakeholders, political parties, and the public that the effectiveness and outcomes of our health system are increasingly dependent on the functioning of social care, and that the resourcing of social care and health must be considered jointly as their fortunes are so closely tied to each other. Our members see the damaging effects the growing crisis in the provision of social care is having day in and out on the NHS's ability to deliver high-quality patient care.
- 9.2 Against this context BMA members are now clear that there needs to be a radical overhaul in the delivery of social care. The current system simply is not working, which is why we believe it is time for social care, like the NHS, to be publicly funded and provided free at the point of delivery. In addition, closer integration between social care and health is required via structural reforms to create truly integrated services.
- 9.3 However, prior to any such reform it is imperative the social care system receives an immediate funding boost to ensure the social care crisis does not deepen with further ramifications for NHS performance. Estimates vary as to how much immediate additional funding is required to stabilise the provider market, along with meeting the growing cost and demographic pressures.²³ The LGA estimates the social care sector could face a £3.5 billion funding gap by 2025 just to maintain current levels of care²⁴. The Government must set out plans to invest in and reform social care as early as possible this year – further delay will compound the uncertainty and pressures being caused by current lack of social care provision in many local areas.

¹ BMA (2020) Pressure points in the NHS: <https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/monitoring-quality-in-the-nhs/pressure-points-in-the-nhs>

² IFS (2019) Conservative manifesto: an initial reaction from IFS researchers: <https://www.ifs.org.uk/election/2019/article/conservative-manifesto-an-initial-reaction-from-ifs-researchers>

³ NAO (2020) NHS financial management and sustainability: <https://www.nao.org.uk/wp-content/uploads/2020/02/NHS-financial-management-and-sustainability.pdf>

⁴ BMA (2018) BMA position on NHS funding: <https://www.bma.org.uk/collective-voice/influence/key-negotiations/nhs-funding/bma-position-on-health-spend>

⁵ BMA (2020) The impact of punitive pensions taxation rules on doctors and the delivery of NHS services: <https://beta.bma.org.uk/media/2002/bma-briefing-on-the-impact-of-pension-taxation-jan-2020.pdf>

⁶ Office of Tax Simplification (2019) Taxation and Life Events: Simplifying tax for individuals: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/838130/Taxation_and_life_events_Oct_2019.pdf

⁷ The Times (2019) We ought to worry about those just under the pension age: <https://www.thetimes.co.uk/article/we-ought-to-worry-too-about-those-people-just-under-the-pension-age-t0g0v09z3>

⁸ BMA (2020) The impact of punitive pension tax rules on doctors and the delivery of NHS services: <https://beta.bma.org.uk/media/2002/bma-briefing-on-the-impact-of-pension-taxation-jan-2020.pdf>

⁹ Ibid.

¹⁰ BMA (2019) Submission of evidence to the Doctors' and Dentists' Remuneration Review Body: <https://www.bma.org.uk/collective-voice/influence/key-negotiations/doctors-pay/annual-pay-review-from-the-ddrb>

¹¹ BMA (2019) Beds in the NHS: <http://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/monitoring-quality-in-the-nhs/beds-in-the-nhs>

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- ¹² The Health Foundation (2019) Investing in The NHS long term plan: <http://www.health.org.uk/publications/reports/investing-in-the-nhs-long-term-plan>
- ¹³ NAO (2020) NHS financial management and sustainability: <https://www.nao.org.uk/report/nhs-financial-management-and-sustainability>
- ¹⁴ BMA (2019) Quarterly survey Q1 2019: <http://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/quarterly-survey/quarterly-survey-results/quarterly-survey-q1-2019>
- ¹⁵ The Guardian (2019) Fire chiefs threaten to close dangerous hospitals: <https://www.theguardian.com/society/2019/jul/09/fire-chiefs-threaten-to-close-dangerous-hospitals>
- ¹⁶ BMA (2019) BMA GP Premises Survey results 2018: <https://www.bma.org.uk/advice/employment/gp-practices/premises/bma-gp-premises-survey-results-2018>
- ¹⁷ BMA (2019) Technology infrastructure and data supporting NHS staff: <https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/technology-infrastructure-and-data-supporting-nhs-staff>
- ¹⁸ Ibid.
- ¹⁹ The Health Foundation (2019) Urgent call for £1bn a year to reverse cuts to public health funding: <https://www.health.org.uk/news-and-comment/news/urgent-call-for-1-billion-a-year-to-reverse-cuts-to-public-health-grant>
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- ²¹ British Medical Association (2020) Mental health workforce in England: <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/mental-health-workforce-report>
- ²² The Health Foundation (2019) Investing in The NHS long term plan: <http://www.health.org.uk/publications/reports/investing-in-the-nhs-long-term-plan>
- ²³ Health and Social Care and Housing, Communities and Local Government Committees (2018) Long-term funding of adult social care: <https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf>
- ²⁴ LGA (2018) The lives we want to lead: <https://www.local.gov.uk/about/news/lga-launches-own-green-paper-adult-social-care-reaches-breaking-point>