

Funding priorities for the health and care sector: BMA's submission to the Spring Statement 2022

1. Introduction

- 1.1. **About the BMA.** The British Medical Association (BMA) 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. **This submission sets out the BMA's funding priorities over the next financial year and beyond.** Our key priorities are ensuring there are safe staffing levels in the health system, through expansion and retention of the existing workforce, and that worrying trends in declining population health are reversed, including through the adequate funding of the public health function. We are therefore calling for the expansion of medical school places (paragraphs 3.2 – 3.3), appropriate pay awards and pension taxation reform (paragraph 3.10 – 3.14). Other funding priorities include upgrading the backlog of high-risk and outdated infrastructure in both primary and secondary care (paragraphs 4.2 – 4.3); and investing in the wider determinants of health beyond healthcare to reduce demand in the long-term and put healthcare on a sustainable footing (paragraph 6.9). A full summary of all our asks is set out in the box below.
- 1.3. **Due to health being a devolved matter, the specific calls for investment set out below are England-focussed.** However, many of the issues highlighted are just as pressing in the devolved nations, and we would expect to see any increases in health funding mirrored for the devolved nations through the Barnett formula.



Summary of key asks

Workforce recruitment and retention (section 3)

- Expand medical school places by 11,000 medical graduates per annum on average over the next three years (£2.7bn per year by 2024/25)
- Develop a long-term, publicly available, fully funded workforce plan
- A £1 bn welfare and wellbeing fund for staff
- Enhanced remuneration package including above inflationary pay award and a solution for punitive pension tax rules

Infrastructure (section 4)

- Fix backlog of unfit infrastructure (£9.2 bn one off)
- GP premises upgrade
- IT – publish up to date assessment of funding need

Healthcare delivery and public health (section 5)

- Investment in mental health through doubling long-term plan pledge (£4.6 bn per year by 2024/25) and dedicated support for increased mental health demand as a result of COVID
- Additional funding for the non-COVID care backlog (additional £7bn over what has been pledged) with funding specifically set aside for primary care to support those waiting for treatment
- Adequately fund public health grant (additional £1.4 bn per year by 2024/25), and provide sufficient operational funding for UKHSA and OHID
- Keep free COVID testing for NHS staff and members of the public in contact with the clinically vulnerable

Beyond healthcare (section 6)

- Improve social care services (additional £7.5 bn by 2024/25)
- Free personal care in social care (additional £8.5 bn by 2030/31)
- Commitment to make improving health an explicit objective in every major policy decision

2. The pandemic has reinforced how important a well-resourced health and public health system are to our national security and to protect and grow our economy, yet historical underfunding has led to a lack of resilience in the system.

2.1. Recent announcements from the Government provide a significant boost to funding for the NHS and social care, which represents an essential step in the right direction to enable the delivery of effective health and social care. The recent Spending Review pledged £173.8 bn in real termsⁱ for the Department of Health and Social Care's Budget (DHSC) in the next financial year (2022/23), rising to £176.4 bn by the end of the spending review period in 2024/25. This represents a significant funding boost over pre-pandemic levels – funding levels next year will be more than £25 bn than what they were in 2019/20. But despite this significant cash injection, the total allocated for 2024/25 is still nearly £10 bn lower than the amount needed for recovery of the system (£185.3 bn) as estimated by the Health Foundationⁱⁱ.

2.2. However, a historic lack of funding over the last decade led to a lack of resilience in the health and public health system at the start of the pandemic. Infrastructure and staff have been and remain under extreme pressure. Prior to 2009/10, historical year on year increases in health expenditure (including spending on healthcare and public health) were 4.3%ⁱⁱⁱ. But in the following decade, funding only increased by 1.6% per year, which was not enough to meet the additional health needs of a growing and ageing population. If spending had increased by the historical average of 4.3% in the decade prior to the start of the pandemic, health expenditure in the UK would have been £39 bn higher over that decade.

2.3. As a result of historical underfunding, combined with the high levels of demand brought on by the COVID pandemic, the health system is under unprecedented pressure. In General Practice, appointments reached a record high over the winter of 2021^{iv}. In secondary care, 6 million people were on waiting lists, awaiting elective care as of December 2021 in England, of which a record nearly 2.2 million had been waiting over 18 weeks^v. 300,000 have been waiting over a year^{vi}. Cancer targets continue to be missed, with first cancer treatment within two months of an urgent referral at a worrying low of 67%. Waiting times in A&E have rocketed, with patients waiting more than 12 hours from decision to admission at a record high over 16,000 in December. And pressures will likely remain high going forwards due to unmet need. Since the start of the pandemic there have been 4.3 million fewer elective

ⁱ Throughout this submission, costings are reported in 2021/22 prices.

ⁱⁱ <https://www.health.org.uk/publications/health-and-social-care-funding-projections-2021>

ⁱⁱⁱ <https://ifs.org.uk/uploads/IFS-Green-Budget-2021-.pdf>

^{iv} <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice-data-analysis>

^v <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis>

^{vi} Ibid

procedures and 29.4 million fewer outpatient attendances, storing up pressures on services in the future^{vii}.

- 2.4. Pressures have been exacerbated by insufficient staffing.** The present lack of official, publicly available workforce planning or national strategy makes it difficult to quantify the full extent of staffing gaps, but chronic workforce shortages across the medical profession have existed for many years. Despite patient numbers rising, the total GP workforce has seen little growth since 2015, with the fully qualified GP workforce actually shrinking over that time. On the secondary care side, 8,158 or 5.8% of medical posts are vacant, with vacancy rates particularly high in the mental health and community sectors. When doctors are compelled to cover chronic staffing gaps purely to deliver a safe service, this leads to doctors being overworked and eventually to burnout, and has long impacted on morale through placing increased and often unjustifiable burdens on doctors. Therefore growing the workforce over the next decade is vital – through both recruitment of new doctors, as well as retention of existing doctors.
- 2.5. Over the next decade, the health and care system will continue to face significant pressure.** One of the largest pressures on NHS spending has been, and is likely to continue to be, the cost implication of rising rates of ill health^{viii}. Disability free life expectancy has been declining and the number of years lived with disability has increased among older age groups since 1990^{ix}. Furthermore, more older adults are now living with multiple long-term health conditions. In addition, developments in new health technologies are likely to improve health but are also putting pressure onto the health system, as technological innovation tends to be cost increasing: studies estimate that technological change accounts for anywhere from 27% to 75% of health care spending growth in recent decades^x. Due to increased cost pressures and increased demand, the Office for Budget Responsibility (OBR) estimates health spending may need to rise to up to 10% of GDP by 2035/36 (from 7.4% pre-pandemic)^{xi}. Health expenditure is increasing in the majority of OECD countries for similar reasons^{xii}, and it is important to be realistic about the need for sustainable funding for the spending needed. It is up to Government to decide which taxes this funding should be leveraged from, but at a minimum it is vital that the level of funding promised through the Spending Review is provided. We note that the £12.4 bn that the Health and Social Care levy is expected to pay for the equivalent of an additional 4 million hospital admissions alongside 29 million appointments in

^{vii} Ibid

^{viii} <https://economy2030.resolutionfoundation.org/wp-content/uploads/2022/02/Under-pressure.pdf>

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<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2018to2020>

^x <https://economy2030.resolutionfoundation.org/wp-content/uploads/2022/02/Under-pressure.pdf>

^{xi} <https://obr.uk/fsr/fiscal-sustainability-report-july-2020/>

^{xii} <https://www.oecd.org/els/health-systems/health-expenditure.htm>

general practice – capacity that the health system vitally needs^{xiii} and if it is withdrawn or delayed, alternative funding sources should be provided. It is also vital that prevention of ill health is prioritised to minimise pressure on the health system and reverse the recent extremely worrying trends in population health.

^{xiii} This was calculated using unit costs from PSSRU uprated by projecting NHS cost inflation based on the last five years to 2022/23 prices, and then allocating 90% of the £12.4 bn expected levy revenue to secondary care and 10% to primary care.

3. Investment is needed to address workforce shortages and grow the NHS workforce, and fair remuneration and pensions for healthcare workers who have consistently gone above and beyond

3.1. Recruitment and retention of staff is a significant issue, if the NHS expects to deliver on its targets and provide a decent quality of care to its patients. There are currently over 8,100 known FTE (full-time equivalent) medical vacancies in the secondary care workforce^{xiv}, whilst GP vacancies are not even collected and published. In England, there are less than 3 doctors per 1,000 patients, whereas OECD comparator EU nations average 3.7 doctors per 1,000 patients. To bring England's doctor/population ratio in line with OECD comparator EU nations of 3.7, we estimate an additional 46,300 FTE doctors are needed (this includes the current 8,100 vacant posts^{xv}. Yet given the growing backlog of unmet patient need, staff are being asked to continually ramp up efforts, for example delivering 30% more elective active activity in 2024/25 than pre-pandemic^{xvi}. In General Practice, despite patient numbers rising, the total GP workforce has seen little growth since 2015, with the fully qualified GP workforce contracting over that time. As of January 2022, there are now the equivalent of 1,608 fewer fully qualified full-time GPs than there were in 2015^{xvii}. This mean there are now only 0.45 fully qualified GPs per 1,000 patients in England, down from 0.52 in 2015. For the GPs that remain, this means increasing numbers of patients to take care of, as the average number of patients each GP is responsible for has increased by around 300 – or 16% - since 2015. This is in stark contrast to the broken UK Government election campaign promises to increase the number of GPs in England by 6,000 by 2025.

Recruitment

3.2. The number of medical school places must sharply increase. In order to expand the workforce so that we have the same number of doctors per patient as comparative countries by 2030, we would need over 11,000 additional medical school places per year over the next three years, at a total cost of £8 bn or £2.7 bn per year^{xviii}. However, given the simultaneous challenges of expanding the teaching space and the academic workforce, we recognise that there may need to be a step-by-step ramping up of new medical school places. In parallel, DHSC and NHSEI must also carry out an assessment of the future healthcare need of the UK population and set out how the remaining medical shortfall will be resolved in the coming decade,

^{xiv} <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey>

^{xv} <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/nhs-medical-staffing-data-analysis>

^{xvi} <https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care/build-back-better-our-plan-for-health-and-social-care>

^{xvii} <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice>

^{xviii} <https://www.bma.org.uk/media/4316/bma-medical-staffing-report-in-england-july-2021.pdf>

jointly with the devolved nations. It is worth considering expanding medical schools into more rural localities as a means of encouraging people to stay there.

- 3.3. **The UK Government must match medical school place expansion with sufficient clinical placements, foundation programme places and corresponding speciality and, crucially, GP training places, working closely with the devolved nations.** This is necessary to ensure a high quality experience for medical trainees and to ensure that they are able to deliver high quality care. The staff/educator workforce, particularly medical academics, in medical schools and NHS providers also needs to expand significantly to deliver the necessary increased teaching, education and supervision workload. A flexible return to work programme for educators is urgently needed to bolster that workforce. Failing to guarantee access to the Foundation Programme and, later on, speciality/GP training places and continuing professional development for staff grade, associate specialist and specialty doctors would contradict efforts to address medical workforce shortages.

Retention

- 3.4. **It is clear that the combined effects of the strain of working through the pandemic, below inflationary pay increases over the last decade, changes to pension rules and difficult working conditions have left many doctors considering their future and changing their retirement plans.** Last year, the BMA found that 32% of respondents to our regular tracker survey were now considering early retirement, compared to just 14% of respondents at the start of the pandemic^{xix}. The BMA believes that, over the next year, the NHS will be faced with an unprecedented level of retirements and numbers of doctors leaving the profession unless the UK Government takes immediate action to keep people in the profession.
- 3.5. **Action must be taken to ensure that the NHS remains an attractive place to work, and to provide an incentive for doctors who are actively considering changing their career plans to instead remain working in the NHS.** For example through reducing bureaucratic workload, focussing on welfare and wellbeing including the provision of occupational health support, and enhancing remuneration packages (including pay, pensions and clinical excellence awards.)
- 3.6. **We should be seeking to cut red tape, remove unhelpful targets/barriers and reduce bureaucratic workload for doctors** to free up capacity for them to do more for their patients, as detailed in our '*Weathering the storm*'^{xx} report. This for example includes pausing all unnecessary mandatory checks and compliance training so they can get through the care backlog quicker.

^{xix} <https://www.bma.org.uk/bma-media-centre/thousands-of-overworked-doctors-plan-to-leave-the-nhs-bma-finds>

^{xx} <https://www.bma.org.uk/media/4834/bma-weathering-the-storm-report-nov21.pdf>

3.7. We are also calling for a welfare and wellbeing fund, to support a series of simple policy interventions to improve the working life of health staff. The Modern Society Initiative have designed a package of measures which would cost £1 bn per year^{xxi}. This would be used to fund free parking, free provision of hot drinks and hot food 24/7, provision of uniform washing services and better provision of scrubs, provision of staff wellbeing spaces, protected break times, consistent shift patterns and better communication and HR support for staff. Such measures are relatively simple to implement and can provide significant psychological benefit in addition to fair remuneration. In return, we expect these measures to improve staff health and wellbeing, improve productivity and staff retention and increase patient satisfaction.

3.8. Improving the provision of occupational health services will also comfortably provide return on investment through improved retention, as well as reduced levels of sickness absence. As the BMA's medical staffing report shows, in England there are currently only 98 specialist occupational physicians in NHS hospital and community health services, a reduction of almost half since 2009, and within this group, there are also a third fewer occupational health consultants^{xxii}. The occupational health workforce will not be able to provide adequate occupational healthcare for NHS staff at these low numbers. While the People Plan states that improved occupational health support with a wider wellbeing offer will be piloted, it does not address our long-standing concerns that basic provision for staff is not available in some parts of the NHS. A comprehensive occupational health service for primary care staff in Scotland is backed by £1 million in current prices with funding provided on a recurring basis^{xxiii}. We estimate that a similar service in England could be delivered at around £11.5 million per year and we expect it to reduce the magnitude of staff sickness absence.

3.9. Over the past decade, doctors have faced declining remuneration packages and sub-inflationary pay awards. Over the last decade doctors have seen their pay fall in real terms. We looked at data on average gross weekly earnings from the Office of National Statistics' Annual Survey of Hours and Earnings^{xxiv}. Between 2011 and 2021, median RPI-adjusted weekly earnings fell significantly more for medical practitioners (reduction of 38%) compared to all workers (reduction of 21%).

3.10. The BMA is calling for above inflationary pay awards, to close the real terms pay erosion doctors have faced over the past decade and reward them for

^{xxi} <https://img1.wsimg.com/blobby/go/cae116ba-fbad-4e8d-9a74-a52593537a00/MSI%20Special%20Report%20Who%20Cares%20For%20Those%20Who%20Car.pdf>

^{xxii} <https://www.bma.org.uk/media/4316/bma-medical-staffing-report-in-england-july-2021.pdf>

^{xxiii} <https://www.gov.scot/news/extra-support-for-gps-and-practice-staff/>

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<https://www.ons.gov.uk/surveys/informationforbusinesses/businesssurveys/annualsurveyofhoursandearnings/ashes>

continuing to contribute to the NHS. We are calling for a rise of RPI + 2% for the majority of doctors, with a 15% rise for junior doctors. A significant proportion of that will be returned to the Treasury in tax revenue. Furthermore, it is a false economy to not remunerate staff appropriately, because of the costs involved in recruiting and training new doctors also comes with a price tag.

- 3.11. **Action must also be taken to uplift the value of both the NCEA and LCEA schemes in recognition of the continued reduction in the overall pot for both schemes.** The value of both schemes has declined in recent years – for example the total value of national CEAs in 2020/21 was 20% lower in real terms than the previous year^{xxv}. And in 2022/23 there will be an estimated spending shortage of £7.5 million from this pot, as clinical academics have been excluded from the methodology for determining how much is available. This has in turn reduced the available pay to consultants at a time where the Government needs to be incentivising consultants to achieve excellence. We therefore call on Government to rectify the issues within these two schemes.
- 3.12. **The current pension system is inappropriately designed and in effect penalises doctors and other higher earners in the NHS.** The combined effects of contribution tiering (with the highest employee contribution rates significantly higher than the lowest contribution tier), the Lifetime Allowance and Annual Allowance limits on tax relief, mean that some doctors not only lose their tax relief on pension contributions, but are in fact taxed double on their contributions, meaning that some doctors face extremely high effective marginal tax rates. This leaves doctors with limited incentives to work additional hours, and many doctors at the height of their careers are choosing to reduce hours or retire early. We welcome recent adjustments to the annual allowance taper rate, as well as the consultation on flattening contribution rates across the NHS workforce, but they do not go far enough.
- 3.13. **The BMA is calling for an immediate review of punitive pension taxation rules.** We would appreciate the opportunity to engage with the Treasury and discuss available options to mitigate the impact these rules are having and will have on the decision for staff at the height of their careers to leave the workforce or reduce hours at a time when we can least afford for them to do so. We suggest the following options are considered: a tax unregistered scheme, similar to the solution offered to judges; immediately introducing mandatory recycling schemes for members who have been left with little option but to opt out of the pensions scheme; and/or making an annual allowance compensation scheme permanent as in 2019/20. An alternative solution would be to scrap the annual allowance for public

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sector defined benefit schemes as it is unsuitable in this type of scheme. Our preferred option is a tax unregistered pension scheme.

3.14. The cost of NHS pensions scheme (NHSPS) membership is also particularly high compared to other public sector schemes. At the top end of the pay scales, doctors pay almost twice as much a year in contributions for a similar pension as civil servants or high court judges. The NHSPS target yield of 9.8% total employee contributions to the scheme also compares unfavourably with a number of other public sector schemes, with the Local Authority scheme at 6.5%, and the Civil Service scheme at 5.6%. We do not agree that the 9.8% average yield needs to be maintained post 2022.

4. Investment is needed to ensure the backlog of poor, inefficient and high-risk infrastructure (estates and technology) is tackled with sufficient capital funding

- 4.1. **We acknowledge and support the recent focus on additional infrastructure investment, totalling over £5.9 bn, as part of a total planned capital budget of £10.3 bn in 2022/23.** Recent announcements to invest in new diagnostic capacity, new surgical hubs and investment in digital transformation and technology are positive, although it is vital that there is sufficient staff to utilise them. This highlights the need for a workforce plan to ensure that new capabilities can be used to their maximum capacity as set out above.

Estates and premises

- 4.2. **The previous decade, though, has seen significant underinvestment in capital – resulting in a huge backlog of maintenance problems, worth at least £9.2bn in secondary care alone.** Capital investment into the NHS has increased in recent years but hasn't kept pace with the rapidly increasing maintenance backlog. A total of £4.5 bn from the DHSC capital budget was transferred to the revenue budget between 2014/15 and 2019/20 to plug gaps there before this practice was halted in 2020/21^{xxvi}. As a result, there has been a failure to invest in existing estates and infrastructure, which has had serious implications for patient safety. In 2020/21 this resulted in 6,812 clinical incidents, where clinical services were delayed, cancelled or interfered with because of estates and infrastructure failures^{xxvii}. The total estimated cost of the maintenance backlog and of repairs to buildings and facilities reported by the NHS provider sector is currently £9.2 bn, of which 50% is considered 'high' or 'significant' (meaning it is likely to cause major disruption to services)^{xxviii}. This is more than the entire capital budget once new investment is taken into account. Further investment of at least £5 bn is needed to eliminate the entire backlog. In addition, the COVID pandemic has made it clear that many estates are unsuitable to deal with the challenges of a highly infectious disease that requires additional measures such as ventilation, isolation rooms, and social distancing, to keep patients and staff safe. While we will need to learn to live with COVID-19 taking additional measures to futureproof the estate will remain important. There may be further variants of concern and there will be new respiratory diseases, so we need to make sure we are ready to respond better in future.
- 4.3. **GP premises also need significant investment.** We have long highlighted the sorry state of general practice premises. Our GP premises survey published in 2018 showed that half of GP practice buildings are not fit for purpose, and only two in

^{xxvi} <https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-capital-investment>

^{xxvii} <https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection>

^{xxviii} <https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection>

every ten practices were fit for the future^{xxix}. The results of our survey informed the General Practice Premises Policy Review, led by NHS England and agreed by the DHSC and the General Practitioners Committee of the BMA. The review reported in June 2019, with a recommendation that *'capital is required both to bring up the standard of current estate and to transform primary care estates across England, to deliver what is required for the clinical and service vision of the Long-Term Plan in purpose-built premises'*^{xxx}. And as with secondary care estates, many GP premises will need additional investment to support improved ventilation, social distancing and the provision of isolation rooms to ensure they are fit for purpose.

- 4.4. We are therefore calling for urgent capital investment in GP through the creation of a new fund for GP premises.** This should be a fund ringfenced for GP premises specifically. It should be apportioned to localities according to need, based on needs assessments conducted by ICSs.

NHS information technology

- 4.5. The lack of adequate and interoperable IT infrastructure is one of the biggest barriers to creating a more collaborative and coordinated NHS, and results in significant time wasted.** A recent survey by the BMA found that more than a quarter (27%) of doctors lost three or more hours a week as a result of poor and inefficient IT^{xxxi}, further reducing capacity and exacerbating the significant pressures on the NHS due to the pandemic. Overall, we estimate that more than 18 million working hours may be lost in a year due to poor IT.

- 4.6. A full audit of the NHS IT estate should be carried out to give an up to date estimate of the true cost of upgrading it.** In 2019, NHSEI estimated the cost of digital transformation to be around £5.1 bn by 2023/24 with an additional £3 billion to be spent by trusts by 2028/29^{xxxii}. This is £5.4 bn and £2.3 bn respectively in current prices, or £8.5 bn overall. The £2.1 bn announced recently is an excellent start, but is unlikely to be sufficient. The Department of Health should carry out a full audit of the NHS IT estate to estimate the full cost of digital transformation and ensure sufficient funding is provided for it.

- 4.7. Key priorities for IT investment must be interoperability, as well as training to ensure staff are able to efficiently use hardware/software invested in.** Greater interoperability between secondary and primary care would naturally facilitate better communication and better, more coordinated care for patients. A lack of interoperability results in greater duplication of work for doctors, leading to a

^{xxix} <https://www.bmj.com/content/364/bmj.l798>

^{xxx} <https://www.england.nhs.uk/publication/general-practice-premises-policy-review/>

^{xxxi} <https://www.nao.org.uk/wp-content/uploads/2019/05/Digital-transformation-in-the-NHS.pdf>

^{xxxii} <https://www.nao.org.uk/wp-content/uploads/2019/05/Digital-transformation-in-the-NHS.pdf>

greater workload at a time when we can least afford this and patients having to wait longer, and it can also lead to errors which can put patients at risk. Thought must however be given by NHSEI to how time taken by clinicians to undertake the training necessary to share data will be covered during a time of significant strain on NHS capacity.

5. Funds should be directed for healthcare delivery and public health where they are needed, including mental health services, elective recovery, and public health delivery

Mental health

5.1. Prior to the pandemic, the majority of those with a mental health disorder were not receiving treatment, and health providers have reported significant increases in demand and the severity of new referrals due to the pandemic. The effects of COVID-19 on population mental health have been considerable and are likely to continue to be so, with estimates suggesting around 11% more new referrals to mental health services up to 2023^{xxxiii}. The Government has rightly listened to stakeholders such as the BMA and allocated resources to mental health services over the course of the pandemic. However, in light of the scale of unmet need before the pandemic, the COVID backlog and increased demand as a result of the pandemic, we do not believe these funding promises have gone far enough.

5.2. We continue to ask for mental health spending to be doubled in real terms over the period of the NHS Long-Term Plan, alongside increased investment in primary care, public mental health, mental health research and the mental health estate^{xxxiv}. Despite one in six people in the population having a mental health disorder prior to COVID, less than half of people with a disorder were receiving treatment^{xxxv}. This would mean investing at least £4.6 billion a year by 2024/25, and would meet the cost of providing support to everyone with a mental health condition. Dedicated additional funding should be made available to CCGs in the next financial year in light of the increased demand created by COVID-19, which has been estimated by NHS Midlands and Lancashire's Strategy Unity to lead to increased costs of £1 bn across England (based on additional 11% new referrals a year)^{xxxvi}.

Elective recovery

5.3. Further funding is needed to ensure elective recovery targets are met. The Health Foundation estimated 'fast recovery' would cost £17 billion from 2020/21 - 2024/25 to clear the non-COVID care backlog and meet the RTT target (92% seen within 18 weeks) by 2024/25 and assuming that 75% of 'missing patients' return^{xxxvii}. They also have estimated a slower recovery (returning to 2018/19 levels of performance - 87% seen within 18 weeks) by 2028/29 of £14.6 bn total. Given that £10 bn has already

^{xxxiii} <https://www.strategyunitwm.nhs.uk/mental-health-surge-model>

^{xxxiv} <https://www.bma.org.uk/media/2750/bma-the-impact-of-covid-19-on-mental-health-in-england.pdf>

^{xxxv} <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey>

^{xxxvi} <https://www.strategyunitwm.nhs.uk/mental-health-surge-model>

^{xxxvii} <https://www.health.org.uk/publications/health-and-social-care-funding-projections-2021>

been pledged since 2020/21 for the recovery, we estimate a further £5 bn - £7 bn will be needed across the spending review period and beyond^{xxxviii}.

5.4. Primary care is also vital to the elective recovery. Primary care is also necessary, working together with secondary care, to clear the backlog of unmet need. Primary care must support patients with long term conditions who might not have received care over the pandemic as well as patients who are waiting for access to secondary care and so need support in the community whilst they are waiting need additional care on top of business as usual treatment. 10% (roughly equivalent to the primary care share of the NHS budget) of the elective recovery spend should be allocated to primary care to support this, on top of the additional funding required to fully clear the backlog. (This is not to say we think primary care should only receive 10% of the total NHS budget, but points out the need for general practice to also be considered in the elective recovery).

Public health services and health security

- 5.5. COVID-19 has demonstrated the importance of public health services and how they help to reduce pressure on the NHS, through the health protection function, by addressing inequalities at local level and by ensuring healthcare services meet the needs of populations but public health services remain significantly underfunded.** Compared to 2015/16, the public health grant has been significantly cut. When population growth and inflation are taken into account, the 2022/23 grant is 24% lower than 2015/16. This has led directly to the reduction in public health services^{xxxix}. In addition to this, while the pandemic has shown how vital both ongoing and surge health protection capacity is at local level, there is now the unrealistic expectation that this will be maintained, yet the additional local resource for this function (the Outbreak Containment Fund) is being withdrawn.
- 5.6. We should be seeking to restore the public health grant to adequate levels rather than maintaining the low and unambitious level of public health funding of the past few years.** The Health Foundation estimates that in order to restore the grant to its real-terms value and meet increasing cost pressures and demand, the grant should be £4.7 billion by 2024/25. To meet that trajectory, the grant for the upcoming year (2022/23) should have been at least £3.8 billion, or 14% higher than the £3.3 bn allocated. The Outbreak Containment Fund should also be restored.
- 5.7. Health Protection and improvement are crucial areas that should also remain appropriately resourced at central and regional level.** The creation of the new UK Health Security Agency (UKHSA), along with the Office for Health Improvement and Disparities (OHID), signals the commitment to this area, but it is vital that there is sufficient funding for these organisations to appropriately monitor and mitigate significant threats to health and to continue to provide screening and immunisation and other vital public health services. Together, the UKHSA and the OHID should have an operating budget exceeding the prior Public Health England operating budget, to reflect the essential need for these functions.

^{xxxviii} <https://committees.parliament.uk/writtenevidence/41434/pdf/>

^{xxxix} <https://www.nao.org.uk/report/financial-sustainability-of-local-authorities-2018/>

5.8. **Investment in increased capacity through expansion of public health higher specialist training is also needed** to continue to contain the threat of COVID-19 and future threats of infectious diseases, to tackle population health threats such as obesity and inactivity, both directly and through addressing the wider determinants of health and to input into local commissioning of healthcare services, at ICS Board level, to ensure these meet the needs of local populations. We agree with other public health experts that there is a shortage of public health specialists throughout the system. The Faculty of Public Health recommends aiming for a minimum of 30 whole time equivalent Public Health consultants per million population^{xl}. Currently there are between 15 and 24 per million across the nations of the UK. In order to achieve this workforce objective, recruitment to specialty training would need to increase by at least a third: from around 75 to around 100 posts per year across the UK^{xli}.

^{xl} <https://www.fph.org.uk/media/3323/fph-submission-to-csr-2021-final.pdf>

^{xli} Ibid

6. Investment is needed to fund policies that support health beyond healthcare will reduce pressure on the healthcare system in the long run

Living with COVID

- 6.1. It is clear we will have to learn to adjust to the reality of COVID, but in doing so we must retain protections that allow us to do so safely.** Of course there is a desire to ensure taxpayer money is spent efficiently, and to reduce costs to the public purse. However, case rates still remain high, and COVID still poses a serious risk to public health and NHS capacity if cases are allowed to spread rapidly. Living with COVID will require maintaining important measures to ensure that NHS staff and the general public can make informed decisions and live with COVID safely. We support many of the measures in the Living with Covid strategy, including support for ventilation of education settings and the central government estate and ongoing investment in vaccines. But we are also calling for the maintenance of free testing, further protections for the clinically vulnerable and the extension of the enhanced Statutory Sick Pay scheme.
- 6.2. COVID testing for healthcare staff must be maintained from 1st April 2022.** It is vital to protect the health of staff and patients that staff twice weekly testing is maintained, with additional funding provided to CCGs to ensure this can happen rather than taking away from existing strained budgets. We estimate that this will cost £500 million to £800 million.
- 6.3. Funding must also be maintained for PPE for those looking after COVID positive or suspected COVID positive patients.** All measures must be taken to protect the health of staff, and funding must be maintained to ensure staff are protected. In particular, we are calling for FFP3 masks to be used we are calling for FFP3 masks to be in the routine care of COVID positive or suspected COVID positive patients due to the risk of aerosol transmission. This is what the evidence suggests will best protect staff best^{xlii}, and it will also protect the NHS by reducing the number of COVID related staff absences. In addition, we would want funding for additional PPE such as gloves, masks and eye protection to be maintained, to the quality currently recommended in IPC guidance.
- 6.4. COVID testing for the general population must also be maintained from 1st April 2022.** The end to free testing risks creating a two-tier system. We support the retention of free testing for all, so that everyone can easily afford to test themselves regularly. However, at minimum tests should be available for those in contact with those who are clinically vulnerable (not just for those who are we are clinically vulnerable themselves). In addition, we are calling for a quota of free tests should also be available for the general public with the lowest incomes, to mitigate the inequalities in access to COVID tests for those least able to afford them.

^{xlii} <https://pubmed.ncbi.nlm.nih.gov/34783656/>

6.5. A robust sick pay system is essential to safeguard the incomes of those who become sick and ensure those that are infectious stay away from their workplaces.

We strongly supported enhancement of Statutory Sick Pay (SSP) during the height of the pandemic, on the grounds that the UK has one of the lowest rates of sick pay in Europe. This must be maintained for the immediate future, as well as the suspension of the three day waiting period, to ensure that those who are potentially infectious do not bring it into their workplaces, allowing viruses to spread and mutate more easily.

Social care

6.6. Increased pressure on the social care system is resulting in rising levels of unmet need, increasingly impacting the NHS and causing unnecessary strain on critical services.

People are living longer lives with more complex needs, and as a result demand is rising faster than the system can currently cope with^{xliii}. This, in turn, impacts the NHS. People remain in hospital beyond the point at which they require urgent medical care waiting for appropriate care packages, causing distress and impacting resources.

6.7. Significant investment is needed in key areas of the social care sector.

There must be an overall funding boost, beyond the £5.4 bn allocated to social care through the Health and Social Care levy announcement. This investment should be targeted towards investing in the social care workforce, as well as meeting current and future demand as a result of an ageing population. Staffing shortages are a major and chronic issue for the social care sector, with the latest data showing 105,000 vacancies advertised on the average day in 2020/21^{xliv}. One of the ways for low paying sectors such as social care to retain and attract more highly-skilled and experienced staff is by creating opportunities for salary and career progression. Ensuring social care employment terms and conditions mirror those of the NHS would help with this. We estimate this will require a further £7.5 bn a year by 2024/25, based on Health Foundation analysis and updating for recent funding announcements^{xlv}.

6.8. We welcome the renewed focus on integration between the health and social care sector, as exemplified in the Levelling Up white paper^{xlvi}.

Integration of local NHS, social care and community services can help prevent people from needing to go into a care home, as well as preventing avoidable need for NHS care. However, better

^{xliii} <https://www.bma.org.uk/media/3216/bma-calling-for-action-for-social-care-in-england-report-sept-2020.pdf>

^{xliv} <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx>

^{xlv} <https://www.health.org.uk/publications/health-and-social-care-funding-projections-2021>

^{xlvi} <https://www.gov.uk/government/publications/levelling-up-the-united-kingdom>

integration between services is no replacement for properly funding them. More integration is also little good if there aren't enough staff to deliver services.

Beyond health and social care

6.9. Improving the nation's health should be seen as an investment in our future and a way to boost the economy. The total economic cost of lost output and health costs have been estimated at around £100bn a year^{xlvi}. The economic gains from closing place-based health inequality could be significant, with analysis by the IPPR suggesting that closing the health gap between the north of England and the rest of England could generate almost £20 bn in Gross Value Added to the economy. The recent Levelling Up White Paper enshrined the government's pledge to improve healthy life expectancy overall and narrow gaps in healthy life expectancy between local places in the UK by over the next two decades^{xlvi}. To ensure this pledge is realised, action must be taken across all government departments, not just the Department of Health and Social Care and the NHS, and we are calling for a new commitment to make improving health an explicit objective in every major policy decision. As discussed above, it is vital that the new Office of Health Improvement and Disparities is adequately funded, to help coordinate health improving activity.

^{xlvi} <https://www.gov.uk/government/statistics/work-health-and-disability-green-paper-data-pack>

^{xlvi} <https://www.gov.uk/government/news/government-unveils-levelling-up-plan-that-will-transform-uk>