Standing up for doctors
Standing up for health
The BMA manifesto
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Our manifesto

A UK General Election will be called at some stage in the next few months. It is widely agreed that a major component of the background to the election will be the substantial ramifications of the economic downturn. In this unsettling environment, tough questions are being asked about what the priorities should be for our public services with the NHS continuing to be the subject of close scrutiny. There are a variety of views on what might be potential answers and the forthcoming election offers the opportunity for thorough debate around what should be the best and most practical policy solutions.

I am pleased to present the BMA’s manifesto for the next UK General Election. This manifesto represents doctors’ views of the key areas of action for health and health care. It forms our contribution to public debate on the challenges facing the NHS in these uncertain times and how these challenges should be met. We are committed to a health service that is properly resourced, comprehensive, free at the point of delivery and provides equal access for all. These are the founding principles of the NHS which have stood the test of time and must continue. An incoming government could both deliver efficiency savings and win back the goodwill of health care staff by pursuing policies based on a vision of the NHS as a publicly-funded, publicly-provided service, rather than a marketplace of competing providers.

Looking to the future, there is no doubt that continued investment in the NHS across the UK, even during a time of financial stringency, is vital. In our manifesto, we hold the view that standing up for doctors is consistent with standing up for the health of the nation. By this we mean that the workforce and the infrastructure to deliver patient care must be robust as demand for services continues to increase. Through our manifesto, we are calling for an incoming government to ensure that the NHS is sustainable in the long term; that we move away from the divisive policy of a market in health care; that the medical workforce is supported to deliver high-quality patient care; and that there is a focus on improving and protecting the nation’s health on areas such as alcohol, tobacco, obesity and the facilitation of a public debate on a move to an opt-out system of organ donation. We also draw attention to future health challenges arising from climate change. We believe that these are principles that the political parties should view as key for the NHS and that governments throughout the UK should share. We are willing to work with policy makers to ensure that there is a carefully-considered and proportionate response to the challenges ahead in the period of financial austerity.

Doctors play a vital role in improving people’s health and the quality of health care. We believe that our manifesto offers a coherent range of policies and ideas and we encourage the political parties to participate in debate on these as they consider the way ahead.

Dr Hamish Meldrum
Chairman of Council, BMA
The BMA is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK.
About the BMA

The BMA is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK. It has a membership of over 140,000, which continues to grow each year. The BMA is the voice for doctors and medical students – in constant contact with ministers, government departments, and members of the Westminster, Scottish, Welsh and Northern Ireland administrations. The BMA is committed to keeping the administrations in touch with the medical profession’s collective views and policies and being at the forefront of health care development.

Setting the Scene

Doctors remain committed to a National Health Service (NHS) which is comprehensive, free at the point of use, organised with a public service ethos, funded from general taxation and which ensures equity of access to care regardless of factors such as age and geographical location. The NHS provides better value for money than any comparable health care system in the world.

The NHS is the largest employer in Europe. It employs approximately 1.5 million staff nationwide and provides an enormous range of services to over 60 million people. Approximately 161,624 are doctors.

On average, every day in the NHS:

- 1,003,968 people visit their family doctors
- 3,884,921 prescriptions are dispensed by the UK Family Health Services
- 250,397 prescriptions are dispensed by dispensing doctors
- 42,548 people receive treatment in accident and emergency departments
- 329,655 people are seen as out-patients
- 29,623 people are admitted to hospital
- 26,449 operations are carried out; 12,078 are in-patient cases and 14,371 are day cases
- 2,052 babies are delivered.

It is health professionals' commitment and dedication to the NHS which has enabled the NHS to survive.

Contact

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Doctors in all branches of medicine play vital roles in improving people’s health and the quality of health care...
**Summary**  Standing up for doctors, Standing up for health

**Introduction**
Debate on public expenditure will be a key focal point in the next UK General Election. With public services under close scrutiny, it would be all too easy to look for quick savings and short-term cuts in the NHS, pointing to perceived shortcomings and failures in the system as reasons to divert monies elsewhere. Now more than ever, it is time to acknowledge the successes of the NHS and, as it seeks to continue to improve and provide the highest quality of care that its patients deserve, to renew investment and ensure that, as the UK faces the challenging times ahead, the NHS is there to support and care for the population when times are hard.

Doctors in all branches of medicine play vital roles in improving people’s health and the quality of health care. The BMA calls on the political parties to endorse the proposals of this manifesto; by adopting and acting on them, an incoming government will deliver a health service that patients deserve.

Although this manifesto is our contribution to debate for the next UK General Election, as health is a devolved matter, we acknowledge that it will largely affect the NHS in England. However, we believe that the overarching principles of NHS sustainability, support for the medical workforce and a focus on improving and protecting health should be shared throughout the UK.

**Commit to making the NHS sustainable in the long term**
In part one of the manifesto (pages 11-17), we set out how government can deliver the best value for taxpayers by emphasising that any NHS reform must be based on the values of cooperation, strategic planning and equity and should deliver joined-up care for the benefit of patients. The imposition of expensive market reforms such as the Private Finance Initiative (PFI) or Independent Sector Treatment Centres (ISTCs), Payment by Results (PbR) and the purchaser-provider split in England, for example, are opposed by the BMA, particularly during a period when public finances are being squeezed. There is a growing need to reconcile ever-increasing expectations about the role and operation of the NHS with the reality of its finite resources and addressing openly what the NHS can credibly offer while ensuring that it is sustainable in the long term.

The BMA calls on the political parties to:
- be realistic about what the NHS can deliver
- recognise that the UK needs investment in health more than ever
- pursue sound and evidence-based planning of services.

The BMA manifesto
Support the medical workforce

In part two of the manifesto (pages 19-29), we consider how government can support the medical workforce to deliver high-quality patient care. This is vital given that the current economic climate will lead to increasing demands being made on the health service. Improved quality of care is very much dependent on a full workforce complement of well-trained and appropriately-regulated staff. With the modernisation of health care delivery comes the need to modernise and improve conditions for doctors.

The BMA calls on the political parties to:

- provide fair working conditions and rewards which are essential for the delivery of high-quality health care to the population
- ensure that high-quality undergraduate education, postgraduate training, continuing professional development and research are accessible
- free doctors from political interference to work with other health professionals and managers to improve care across the NHS.

Improved quality of care is very much dependent on a full workforce complement of well-trained and appropriately-regulated staff.
Furthermore, the various components of the medical workforce have also identified specific proposals:

**General practitioners** call on the political parties to:
- safeguard patient-centred general practice
- engage with GPs in the design and implementation of policy
- support and develop general practice to deliver high-quality care for patients.

**Consultants** call on the political parties to:
- support meaningful choice for patients
- rethink targets
- value medical leadership
- promote innovation in the delivery of patient care
- invest in a consultant-based service.

**Staff grades, specialty doctors and associate specialists** call on the political parties to:
- facilitate access to training for staff grades, specialty doctors and associate specialists in order to promote the SAS grades as a positive career choice
- ensure that the new specialty doctor contract is available to all eligible doctors and is swiftly and fairly implemented
- pledge that SAS doctors will not be adversely affected by European Working Time Directive (EWTD) implementation.

**Junior doctors** call on the political parties to:
- negotiate a new junior doctor contract
- review and improve junior doctor training
- recognise the value to the NHS of overseas doctors
- recognise and value the contribution of junior doctors to the NHS.

**Medical students** call on the political parties to:
- support entry to medicine by under-represented groups
- maintain the cap on student tuition fees in England
- ensure an equitable and transparent entry system to postgraduate education.

**Medical academics** call on the political parties to:
- acknowledge the value of research and education to the nation's health
- halt the decline in the medical academic workforce
- support medical research
- maintain a balance between patient confidentiality and access to data for medical research.
The BMA calls on the political parties to take strong action to tackle alcohol-related harm:
- support increases in alcohol duty above the rate of inflation proportionate to the amount of alcohol in the product
- support minimum price levels for the sale of alcoholic beverages and end irresponsible promotional activities like happy hours and two-for-one offers
- support the display of information on recommended drinking guidelines and health warnings on all alcoholic products, at the point of sale, and in all printed and electronic media
- legislate for a total ban on alcohol advertising in the media
- support the reduction in the opening hours of both on- and off-licensed premises
- ensure more funding, training and support to detect and manage people with alcohol misuse problems
- reduce the legal limit for the level of alcohol permitted while driving from 80mg/100ml to no more than 50mg/100ml throughout the UK.

The BMA calls on the political parties to create a tobacco-free society by 2035:
- standardise and increase taxation on all tobacco products at higher than inflation rates
- ensure that smoking cessation services are adequately funded and resourced, and targeted at high-risk groups
- compel outlets selling tobacco to get a licence to do so
- introduce plain packaging on cigarette packets with only the brand name and health warnings
- set minimum price levels for tobacco products
- complete prohibition of the sale of tobacco from vending machines throughout the UK
- implement a sustained population-wide communications programme promoting anti-smoking messages and imagery
- take action to combat tobacco smuggling and trade in counterfeit cigarettes
- recognise that the British Board of Film Classification should take pro-smoking content into consideration for the classification of films, videos and digital material in the UK. This should consider whether the depiction of smoking is condoned, encouraged or glamorised in the absence of editorial justification.

Focus on improving and protecting health

In part three of the manifesto (pages 31-37), we state that action to improve and protect the health of the nation must remain the priority for an incoming government, especially as recession has a negative impact on health. This manifesto outlines key steps to attain public health gains in tackling alcohol, tobacco and obesity, as well as drawing attention to the future health challenges arising from climate change. We also include the need for there to be a public debate on an opt-out system for organ donation.
The BMA calls on the political parties to deal with the obesity crisis and promote exercise:
- ensure that the food and drink industry implement a standardised, consistent approach to food labelling based upon the traffic-light front-of-pack labelling recommended by the Food Standards Agency (FSA). Labelling should also include Guideline Daily Amount (GDA) information
- legislate for a ban on the advertising of unhealthy foodstuffs, including inappropriate sponsorship programmes, targeted at schoolchildren
- make more extensive use of the media, including children’s programming, to promote healthy lifestyle messages that make such lifestyles both fun and aspirational
- introduce a legal obligation to reduce salt, sugar and fat in pre-prepared meals, and mandatory nutrient and compositional standards for school meals
- develop a strategy to encourage children and young people to take part in regular exercise
- increase and protect access to recreational facilities (e.g., public swimming pools and playing fields) regardless of socio-economic status and level of physical and psychological ability
- promote active travel networks by providing safe environments for pedestrians and cyclists and ensuring that there is appropriate support of the built environment by local and central government. Furthermore, there should be increased provision of facilities for the combination of cycling with rail and other travel.

The BMA calls on the political parties to facilitate an informed public debate on an opt-out system for organ donation:
- continue to invest in a well-funded and well-organised system for organ donation
- at the same time, facilitate an informed public debate about a shift to an opt-out system for organ donation (presumed consent).

The BMA calls on the political parties to act decisively on climate change:
- act decisively and quickly to introduce effective action on climate change
- develop binding and enforceable carbon footprint reduction guidelines for the NHS
- promote energy efficiency
- support initiatives to promote the health co-benefits of actions aimed to mitigate climate change (e.g., reducing car use will equate to a reduction in CO2 emissions, result in increased levels of physical activity and could also lead to a reduction in accidents through safer roads and public spaces)
- regularly review the evidence on mitigation and adaptation policies (such as greening public spaces) and implement those that will make a difference to the UK and increase or contribute to global sustainability.
Doctors strongly believe that any NHS reform must be based on the values of cooperation, strategic planning and equity and should deliver joined-up care for the benefit of patients...
Part one

Commit to making the NHS sustainable in the long term

Introduction

Health care should be free at the point of delivery, provided with a public service ethos, ethically rationed by clinical priority without discrimination, equitably resourced and funded out of general taxation. These fundamental factors are the core values of the NHS and doctors continue to support them. Changes in society, demography, the organisation of health care, rising patient expectation and advances in techniques of medical care have meant that there are increasing demands placed on the NHS. However, doctors have repeatedly demonstrated clinical leadership in their ability to foster innovation and to cope with reform and evolve services with patient care at their centre.

Doctors strongly believe that any NHS reform must be based on the values of cooperation, strategic planning and equity and should deliver joined-up care for the benefit of patients. Future sustainability must remain a key priority for the NHS.

Be realistic about what the NHS can deliver

It is time for greater honesty about the tension that exists between the principles of equity and autonomy in the modern, tax-funded NHS where patient choice and personalisation are expected to play an increasingly central role.

There is a growing need to reconcile ever-increasing public and patient expectations about the role and operation of the NHS, championed as a provider of universal and comprehensive care, with the reality of its finite resources. Now particularly, in a period of financial constraint and with a tightening of the public purse, it is necessary to address openly what the NHS can credibly offer in the context of a consumer-orientated, personalised, and information-rich society.

Doctors therefore wish to see much greater opportunity for an open and informed dialogue on the issue of resource allocation in the NHS. This does not suggest a commitment to any form of explicit rationing, only to engaging the public, patients and health professionals in a mature debate about the true cost of delivering health services and the means of ensuring a transparent framework for making decisions involving priorities and the allocation of NHS resources.

This dialogue must work toward developing a sustainable and high-quality NHS for the future that balances the best interests of patients, value for money for taxpayers and faithfulness to the core principle of equity that underpins the NHS.

The BMA calls on the political parties to:

• be realistic about what the NHS can deliver
• recognise that the UK needs investment in health more than ever
• pursue sound and evidence-based planning of services.
In so doing, valuable NHS resources must be allocated in a justified and accountable way, delivering care at the frontline to the patients and the areas most in need, not wasted on ill-judged reforms and politically-driven initiatives.

With the future of public finances looking bleak, it would be all too easy to look for quick savings and short-term cuts in the NHS, pointing to perceived shortcomings and failures in the system as reasons to divert monies elsewhere. Now more than ever, it is time to acknowledge the successes of the NHS and, as it seeks to continue to improve and provide the highest quality of care that its patients deserve, to renew investment and ensure that, as the UK faces the challenging times ahead, the NHS is there to support and care for the population when times are hard.

It is important to mention at this point that we are pleased that there is a debate in England on long-term funding for social care. This discussion is timely as reform of a chronically under-funded social care service is needed. We also welcome the debate regarding raising the quality of social care – we believe that this will not be achieved without well-trained and supported staff. Furthermore, failing to support the increasing amount of care being provided by carers and improving the quality of life of the carer and the cared for will result in an increased demand for NHS services.

**Recognise that the UK needs investment in health now more than ever**

The NHS and its contribution to society and modern life are essential and deserve our support.

The NHS has a duty to allocate resources to obtain the greatest benefit. There must be a renewed focus on NHS funding being used predominantly for patient services. We define ‘efficiency’ as being the duty to allocate NHS resources to obtain the greatest benefit in terms of patient care. However, increasingly, the concept of efficiency is linked with financial targets and cutting costs in the NHS. As such, in working through the recession, politicians should focus on challenging expensive and ill-thought-out, market-based policies, for example, those such as the Private Finance Initiative (PFI) and the overuse of management consultants.

The current economic climate means that increasing demands will be made on the NHS. Being unemployed or losing your home has significant health consequences for individuals, their families and their community. It is clear that there are strong associations between unemployment, anxiety and depression, and a raised mortality rate from suicide and accidents.
The NHS is essential to improving health and wellbeing across the UK and in doing so contributes to the wider economy and the nation. Individuals, employers, the government, and society all benefit from improved levels of health arising from curing sickness and preventing disease.

Now is the time to support and protect frontline services and make sure that clinical quality and patient safety are not compromised. There has to be a move away from any idea that certain services are ‘soft targets’ for making economies. It is imperative to maintain and increase current investment in mental health services and services for vulnerable patients, such as children and the elderly.

Education, training for medical professionals and research represent sound investments in the future of our health service and the health of our nation. When cuts are achieved simply by squeezing local budgets, expenditure on the education and training of professional staff is often regarded as an easy target. This is a dangerous and short-sighted response, which risks long-term damage to the quality infrastructure of the health service. Protections must therefore be put in place against ‘slash and burn’ responses to the need for savings.

There has been political debate on the sustainability of public sector pensions, perhaps inevitably given the current economic climate. However, it is important to recognise that very significant changes to the NHS pension scheme have only recently been agreed with government. Key changes included cost-sharing arrangements between employers and staff to limit the cost of the pension scheme and to contain long-term costs to the NHS. It is essential that there is no long-term damage to the NHS infrastructure by destroying the morale and motivation of staff. Therefore, there should be no further changes to the agreed NHS pension scheme; this is crucial to encourage the recruitment and retention of doctors to the workforce, rewarding those who wish to stay in the NHS.

Now is the time to support and protect frontline services and make sure that clinical quality and patient safety are not compromised.
Any efforts to reduce expenditure should focus on strategic improvements – through greater productivity, intelligent redesign of services and giving priority to frontline patient care. It would be a disastrous error to resort to simplistic measures like cutting the jobs of medical and other clinical staff, at a time when, as a consequence of the economic situation, demand for health care is increasing, not diminishing.

Doctors serve their individual patients but also have a duty to whole families and communities, treating illness and promoting health. Failing to meet the population’s needs as a result of the recession’s impact on health would have profound and long-term effects. It would be harder to address these problems in the future as they will have become more entrenched over time. Now is the time to invest in health promotion and public health initiatives that improve health outcomes and reduce demand on the NHS in the future. In this manifesto, for example, we have outlined our support for tackling alcohol-related harm, tobacco use, the obesity crisis and climate change.

The public sector has played, and is playing, a significant role in the UK’s recovery. It is looking out for the most vulnerable and keeping our communities together. Cuts to frontline services will put the UK’s economic recovery at risk and threaten a deeper recession. Redundancies amongst clinical staff would have the double effect of reducing the effectiveness of the NHS while increasing the number of unemployed people needing assistance.

It is essential that policy makers respond proportionately and consider the long-term implications of any decisions that are made. We believe that doctors are ready to play their part in making sure that the NHS responds proportionately to the financial crisis. We extend our offer of expertise to policy makers to ensure that as the UK faces the challenging times ahead, the NHS is there to support and care for the population.

It is essential that policy makers respond proportionately and consider the long-term implications of any decisions that are made.
Pursue sound and evidence-based planning of services
The commissioning or planning of patient care and services is a key function of a National Health Service seeking to balance the clinical needs of patients with the finite resources that society is prepared to make available via general taxation. Most importantly, effective commissioning has the potential to improve the range and quality of health services available to patients. This can only be achieved by cooperation and if a public service ethos is maintained. By associating commissioning with ideological reforms or policies, such as pursuit of a market in the NHS, its core purpose is can be subverted and diluted, ultimately to the detriment of patient care.

The current financial crisis and uncertainty around the level of funding that the NHS will receive in the coming years makes it more important than ever before that at the heart of commissioning lies evidence-based medicine. Part of this approach should be to disinvest in pathways, treatments and/or drugs that are not as effective as other options available to patients. In addition, decision-making should be transparent and accountable as this is the only way to establish and maintain trust with patients and the public.

An appropriate balance between cost-effectiveness, quality and long-term sustainability should be promoted. Sound planning resists short-term and ill-thought-out changes whose prime function is simply to reduce costs, in the knowledge that such an approach is likely to result in long-term problems for the NHS and health of the population.

It is important to ensure that NHS facilities and services are not destabilised or fragmented. Policies are too often developed without the involvement of doctors’ representatives, other health care professionals, patients and the public. This can lead to reforms that are impractical to implement or ignore patient needs. Doctors should be involved at an early stage of all health policy development to ensure that policies are workable and consequently are more likely to be welcomed and implemented effectively by doctors.

The BMA values the special patient-doctor relationship and the importance of continuity of care. Doctors act as interpreters of information for patients, supporting their decision making about health choices. Patients rely on doctors to provide competent reassurance and guidance based on mutual trust and understanding built up over time. But fragmentation of service provision puts this at risk.

The public needs to be able to rely on the NHS remaining a comprehensive service free at the point of delivery. The patient’s journey must be improved by developing more integrated services that are patient-focused across primary and secondary care and across health and social care. Health care services need to be based on cooperation rather than competition. Doctors are concerned that uncontrolled competition, plurality and market-based reforms will result in greater fragmentation of care that will ultimately reduce the standard and quality of care that patients receive.
The NHS in England

The experience of the NHS in England highlights the need for the pursuit of sound and evidence-based planning of services. Due to the hard work of NHS staff, patients have seen real improvements in the health service. Progress in England has often been undermined by poorly-integrated initiatives that are imposed from the centre. Doctors have repeatedly voiced concern that the volume of reform to which the NHS in England has been subject, and the pace of its introduction in recent years, has both destabilised the health service and alienated large sections of its dedicated staff.

There has been a belief by politicians that opening up the NHS to market forces through the creation and continuation of the purchaser-provider split will improve quality and reduce costs. However, when the drivers are profits, shareholder returns, competition, with heavy transactional costs involved, it has to be asked whether patients’ best interests will be served and indeed whether affordability will be enhanced or diminished.

The imposition of market reforms can have a negative impact on the finances of the NHS, with money that could have been spent on patient care going to private companies and shareholders. These reforms have taken various forms such as:

Private Finance Initiative (PFI), where the NHS secures capital from the private sector to build hospitals. These are expensive projects that do not provide value for money or flexible services. The imperative to pay back the private sector is making many hospitals’ financial difficulties worse, leading to cuts in services.

Independent Sector Treatment Centres (ISTCs), where private companies provide surgical and diagnostic procedures to NHS patients. These private companies have been paid large amounts of taxpayers’ money up-front to carry out a high volume of work, yet many of the ISTCs have not met agreed levels of activity and will therefore receive payment for work not carried out.

Payment by Results (PbR), whereby hospitals are paid according to the number of admissions they provide, conflicts with other policies. Under PbR hospitals are encouraged to treat more patients, while under practice based commissioning general practitioners (GPs) are encouraged to refer less to hospital services. This can act to prevent the development of coordinated services that deliver the best care for patients.
**Plurality of provision**, where non-NHS providers, such as the private/commercial sector, are being encouraged to compete to provide services. For example, the UK’s unique system of general practice should not be diluted through inappropriate or excessive use of the private sector through the use of large companies whose directors are not involved in direct patient care in the local community. The emphasis on competition will lead to valuable time and money being spent on bureaucracy managing competition rather than delivering care to patients. It also depends on unaffordable levels of over capacity.

The continued or increased use of such reforms is opposed by the BMA particularly as public finances are in such a difficult state. The promotion of such reforms leads to competition and division rather than cooperation and collaboration, with the risk of closure of local services due to competitive pressures. Education and training, which are vital, could be neglected as there is little or no financial incentive for private providers to train doctors in the way the NHS does. Doctors believe that professional judgements about what’s best for patients are sidelined in the interests of profits and shareholders.

Better coordination between different parts of the health service is unlikely to be achieved when the health system relies on market forces and providers are competing with one another. It is therefore imperative that a new approach is adopted, focusing instead on encouraging cooperation between providers and using comparable health outcomes data to stimulate health professionals to perform better. Policies must be developed with the involvement of NHS staff and patients.

The BMA is campaigning for the NHS to be restored as a public service working cooperatively for patients, not a market of commercial businesses competing with each other for financial gain. For more information, please see:

[www.lookafterournhs.org](http://www.lookafterournhs.org)
The medical workforce is diverse with doctors at all stages in their career undertaking essential and valuable roles in the provision of a high-quality service for patients...
Part two  Support the medical workforce

Introduction
The UK has first-class doctors and in order to keep them, the NHS must offer fair working conditions and rewards which are appropriate to reflect the skills, expertise and professional status of doctors.

Doctors are at the heart of the NHS, treating patients, improving patient care, educating future professionals, transferring new knowledge into service improvements and redesigning care in a more patient-centred way. An incoming government must invest in the medical workforce for the long term. They must be valued and freed from political interference to work with other health professionals, managers and patients to improve care across the NHS.

Improved quality of care is very much dependent on a full complement of a well-trained and appropriately-regulated workforce. Policies such as the European Working Time Directive (EWTD)\(^\text{19}\) and revalidation\(^\text{20}\) can be of benefit to the public and doctors if properly implemented. The EWTD is important health and safety legislation and the need for its application to doctors in training from August 2009 was understood, but junior doctors have valid concerns over the continuity and quality of their training. The coming introduction of medical revalidation will be challenging in the straitened financial circumstances of the NHS after 2011. The BMA has been calling for a sensible, pragmatic and cost-effective process which genuinely protects patients, does not take doctors away from frontline care and does not create unproductive and unnecessary bureaucracy.

An incoming government must ensure that high-quality undergraduate education, postgraduate training, and continuing professional development are accessible for all doctors who wish to pursue a career in the NHS. With the modernisation of health care delivery must come the need to modernise and improve conditions for doctors.

The medical workforce is diverse with doctors at all stages in their career undertaking essential and valuable roles in the provision of a high-quality service for patients in the NHS. The various components can loosely be identified as general practitioners, consultants, junior doctors, medical students, medical academics, staff grades, specialty doctors and associate specialist doctors plus doctors working at various levels in a range of other settings including prisons, the armed forces, occupational health etc.

However, clinical care for patients is only one of the many roles doctors in the NHS undertake. Medical input and leadership are essential to many other areas including health policy development and implementation, management, academic research, education and training, leadership and mentoring, clinical effectiveness and service improvement.

The BMA calls on the political parties to:

• provide fair working conditions and rewards which are essential for the delivery of high-quality health care to the population
• ensure that high-quality undergraduate education, postgraduate training, and continuing professional development and research are accessible
• free doctors from political interference to work with other health professionals and managers to improve care across the NHS.
General practitioners

General practice has been the cornerstone of the NHS since its inception in 1948 and is central in providing patients with long-term continuity of high-quality, personalised health care. UK general practice is internationally renowned as the foundation of the most cost-effective form of health care delivery in the developed world and is highly valued by patients.21 A number of countries with more expensive and fragmented health systems have started to replicate the UK system of general practice, with its emphasis on equity of access via registered patient lists with the general practitioner (GP) providing the gateway to other parts of the service. This ensures the coordination, continuity and comprehensiveness of health care, and includes a unique payment system linked to positive health care outcomes. The Quality and Outcomes Framework (QOF)22 has had a positive impact on the treatment of chronic disease and there is encouraging evidence that it is reducing health inequalities.

The BMA calls on the political parties to:
• safeguard patient-centred general practice
• engage with GPs in the design and implementation of policy
• support and develop general practice to deliver high-quality care for patients.

Safeguard patient-centred general practice

Continuity of high-quality care is delivered by mainstream general practice and is particularly valued by those patients who access GP services frequently. This must not be jeopardised by fragmentation of services. The UK’s unique system of general practice should also not be diluted or damaged through inappropriate or excessive involvement of the private sector through the use of large companies whose directors are not involved in direct patient care in the local community. The strengths of general practice such as the practice list system, continuity of care from the cradle to the grave, and the provision of holistic and increasingly complex care, and independent advocacy by locally known and trusted clinicians, should be strongly supported.

Engage with GPs in the design and implementation of policy

GPs must be involved in the development and implementation of policy to deliver positive outcomes for patients and increase the chances of such policy being workable, effective and supported by GPs themselves. For example, GPs must be more involved in developing initiatives that ensure that patients have real and meaningful choice when a referral is made. Many practices may also be comfortable with the concept of flexible boundaries but major logistical barriers would need to be overcome for patients to be able to register with practices a long distance from home without a whole range of unintended
consequences developing. GP leaders are open to discussions with policy makers on ways of improving choice and increasing primary care services for patients.

Furthermore, GPs must be fully engaged in commissioning or developing services, including out-of-hours services, which are fair and equitable across the country. It is important that GPs are involved in out-of-hours primary care organisations to ensure a high-quality timely and cost-effective service that is sensitive to local circumstances.

GPs believe that the crude target-setting which creates illogical pressures on appointment systems and distorts clinical priorities should be eliminated. Politically-attractive but superficial and potentially flawed policies that benefit neither patients nor the NHS in the longer term should be avoided. Like GPs, all governments want to achieve better care, better patient experience, and better value for money. General practice is already excellent value for money and GPs believe that responding to the wishes and views of their own patients, measured locally, is the best way to build on this and further improve patient services. Listening directly to local patients is a far better and more cost-effective way to achieve this than blunt national surveys.

Support and develop general practice to deliver high-quality care for patients

Many patients need longer consultations with their GP or practice nurse. The quality of their care could be improved further if additional resources encouraged longer consultation times. This will require investment in more GPs if current access is to be maintained. It is necessary to improve GP recruitment and retention, properly rewarding GP trainers and educators. GP training should be extended to five years to increase the quality of care provided to patients by equipping future GPs with the skills to deal with increasingly complex care in the community. Practices should be encouraged to offer more GP partnerships, especially in under-doctored areas, and there needs to be greater consideration given to how funding for primary care can be allocated carefully to also provide greater support for growing practices. GP leaders are willing to engage with policy makers on solutions to achieve this.

An incoming government should help existing practices, which are usually at the heart of local communities, to develop their buildings so that they can take on more patients and provide a wider range of services rather than invest in expensive and unnecessary additional facilities, which would be a wasteful use of public money. GP premises need major investment through a new ‘cost rent’ scheme, rather than through expensive PFI projects, to ensure that there are modern and accessible facilities for the provision of services.
Consultants
Patients demand quality of care and will often ask for consultants to be in charge of their hospital care. As the NHS is moving towards a consultant-based service, in many areas, that quality of care is more assured than ever. Consultants are keen to see the NHS improve and they constantly lead change, pioneering new techniques and services. Consultants are determined to see equity and freedom of access preserved, with care provided on the basis of clinical need.

The BMA calls on the political parties to:
• support meaningful choice for patients
• rethink targets
• value medical leadership
• promote innovation in the delivery of patient care
• invest in a consultant-based service.

Support meaningful choice for patients
Consultants support the principle of patient choice but choice needs to be genuine and well informed. Most patients want an assurance that they can expect a high quality of service, care and treatment from their local hospital. Increased resources, both money and staff, would be best deployed to increase capacity in NHS facilities rather than being diverted to Independent Sector Treatment Centres (ISTCs). NHS services themselves should be protected against fragmentation and destabilisation. There are limits to the role the private sector can play, and the NHS must be strengthened.

Rethink targets
Consultants also continue to be concerned about centrally-imposed and clinically-inappropriate targets in the NHS because of their potential to distort clinical priorities. Any new policies proposed should comply with the principle that patients should be treated according to their clinical need. No targets or standards should distort clinical priorities as quality rather than finance should be the driver.

Value medical leadership
Consultants are the key players in NHS clinical teams and are needed to manage and lead the service. They are essential to the success of the NHS and are required for service innovation and development, including clinical research, which improve efficiency or patient outcomes. Consultants play an important role in setting priorities, developing policies and making other management decisions within their own departments and hospitals. By virtue of their longevity in post and their understanding of the day-to-day core business, both as leaders of individual services and in the wider context of hospital management, consultants are key to continuity in hospitals and specialist patient care. Consultants are calling for there to be a focus on medical leadership and greater involvement in the commissioning process to improve quality of care for patients.
Promote innovation in the delivery of patient care
As well as leadership of services and health care professionals, consultants provide leadership and innovation to pioneer and drive forward new treatments and models of care for patients. Innovative practices should be encouraged in the health service and NHS organisations must protect the time that consultants use to develop innovations.

Invest in a consultant-based service
As well as central roles in leadership and innovation, consultants deliver direct patient care, consistently achieving the best and most productive results. Most quality initiatives and workforce reforms involve removing barriers between consultants and patients so that patients can have the right care first time. This clinical workload and this experience feed directly into the continual improvement of services, and it is the two together that are the hallmark of the NHS. Allowing consultants the time to combine both roles is essential; this combination is at the heart of the national consultant contract and underpins the NHS promise to patients. In some places short-sighted cost control threatens this investment, a danger that an incoming government must prevent.

Staff grades, specialty doctors and associate specialists
The NHS employs over 12,500 staff grades, specialty doctors and associate specialist (SAS) doctors, who are neither consultants nor trainees. SAS doctors work in key service roles within the NHS and their numbers expand every year. They undertake high intensity work, including operating on and anaesthetising urgent and emergency patients.

Formerly called non-consultant career grade doctors, this group of staff is now referred to as the SAS group. Doctors in the SAS grades work at a senior career-grade level in hospital and community specialties. The group comprises specialty doctors, staff grades, associate specialists, clinical assistants, hospital practitioners, Senior/Clinical Medical Officers and other non-standard, non-training ‘trust’ grades. Recognition of and investment in this group of doctors is much needed as they are an untapped resource in the NHS.

The BMA calls on the political parties to:
• facilitate access to training for staff grades, specialty doctors and associate specialists in order to promote the SAS grades as a positive career choice
• ensure that the new specialty doctor contract is available to all eligible doctors and is swiftly and fairly implemented
• pledge that SAS doctors will not be adversely affected by EWTD implementation.
Facilitate access to training for SAS doctors

SAS doctors are senior doctors who have direct contact with patients in hospitals and provide a crucial service. The lack of formal recognition of their competencies, skills, experience and hard work coupled with inadequate career progression to consultant or independent practitioner level leaves many feeling frustrated and discouraged. SAS grade doctors need improved access to training in order to further develop their specialist knowledge and skills to enable them to offer their full potential to their employer and the wider NHS. It is only through formal systems for recognition of the competencies of this diverse group of doctors that this grade can be promoted as a positive career choice. Current workforce planning does not facilitate the progression of SAS doctors to consultant grade or independent practitioner level and the training necessary to progress must be made available to SAS doctors. SAS doctors in England have already received a promise of funding to assist in their development. Equivalent funding now needs to be extended to SAS doctors in the devolved nations. This funding should be carefully monitored to ensure its appropriate use. This is essential for the modernisation of the NHS and will also help deliver improved patient care.

Ensure that the new specialty doctor contract is available to all eligible doctors

In March 2008, SAS doctors voted to accept government’s offer of a new national contract. The majority of SAS doctors have been keen to transfer onto the new contract but there have been problems with the implementation process, particularly with dissemination of information. An incoming government must work with employers and the BMA to ensure that all SAS doctors are offered the new contract and that it is implemented equitably across the country.

Pledge that SAS doctors will not be adversely affected by EWTD implementation

The European Working Time Directive (EWTD) is important health and safety legislation and its extension to doctors in training in August 2009 was necessary. SAS doctors already work onerous on-call rotas, as well as long and unsocial hours. Reconfigured services have affected SAS doctors disproportionately and they should not be pressurised into carrying the burden of reduced junior doctor hours. Hospitals have had 12 years to prepare for the implementation of the EWTD and plans should be in place to ensure that no doctor is adversely affected.
Junior doctors

There are approximately 55,000 junior doctors in the UK working in the NHS, playing a significant role in the delivery of patient care. The term ‘junior doctor’ refers to the period that a hospital doctor spends between graduation from medical school and achieving specialist or GP registration. Junior doctors are engaged in hospital or primary care practice while continuing to train.

The BMA calls on the political parties to:
• negotiate a new junior doctor contract
• review and improve junior doctor training
• recognise the value to the NHS of overseas doctors
• recognise and value the contribution of junior doctors to the NHS.

Negotiate a new junior doctor contract
Junior doctors’ lives have changed radically since their current contract was implemented in 2000, with the introduction of Modernising Medical Careers, which reformed medical training, and the implementation of the European Working Time Directive (EWTD), which limits doctors’ working hours. The current contract for junior doctors is now outdated and many of the areas it covers are now irrelevant. Any new contract must reflect the different working patterns and offer juniors fair terms and conditions of service. It must optimise the training that juniors get and the care patients receive, and revitalise and strengthen the relationship between junior doctors and their employing NHS organisations.

Review and improve junior doctor training
The EWTD is important health and safety legislation and the need for its application to doctors in training from August 2009 was understood, but junior doctors have valid concerns over the continuity and quality of their training. The EWTD has provided an opportunity to review the delivery of junior doctor training and to find realistic solutions to concerns about training across all specialties. High standards can be maintained and training improved by using junior doctors more efficiently. Derogations from the regulations were an unfortunate necessity for some under-prepared services and an incoming government must work with employers to ensure full preparedness and compliance when the derogation period comes to an end.

Recognise the value to the NHS of overseas doctors
Overseas doctors are a crucial part of the workforce and are essential to maintaining high-quality standards of care within the NHS. The UK trains thousands of non-EEA medical students and doctors in undergraduate and postgraduate medical education every year at considerable financial cost. Many go on to a career in the NHS. International medical students and overseas doctors have a right to complete their training and qualify as doctors once they have begun their studies, without ill-considered changes to the immigration points-based system putting their careers, and the quality of care in the NHS, in jeopardy.
Recognise and value the contribution of junior doctors to the NHS

Although the NHS has congratulated NHS staff for their contribution over the years, that is not the same as valuing them. Many junior doctors feel increasingly disillusioned with the NHS. There are several areas that need to be addressed, from simple issues such as the provision of office space, car parking and nursery places to more complicated issues such as provision of information to doctors rotating to new posts, the integration of junior doctors into management structures and the provision of flexible training. Many juniors balance their training with other commitments and find it easier to work flexibly. Unfortunately, the process for securing flexible training is still lengthy and complicated and given the demographic changes to the medical workforce, this should be made more accessible. Junior doctors are highly skilled professionals who deliver high-quality care to patients. It is time that the NHS recognises this and changes the way it relates to a large part of its workforce.

Medical students

Medical students are the medical workforce of the future. There are nearly 40,000 students studying medicine in the UK. The years spent at medical school serve as a solid foundation upon which the knowledge, skills, attitudes and behaviour expected of doctors are built so that tomorrow’s doctors are fully prepared to meet the challenges of helping to improve the NHS by delivering effective patient care.

The BMA calls on the political parties to:
• support entry to medicine by under-represented groups
• maintain the cap on student tuition fees in England
• ensure an equitable and transparent entry system to postgraduate education.

Support entry to medicine by under-represented groups

Society is best served by a medical workforce that is representative of, and as diverse as, society itself. Students from traditionally under-represented backgrounds must be encouraged to apply to medicine and supported through their course. The figures for participation in higher education by students from such backgrounds are worryingly low but in medicine they are significantly worse. The BMA’s survey of medical students’ finances shows only 4% of respondents coming from semi-skilled and unskilled occupational backgrounds.
The Panel on Fair Access to the Professions provides a welcome contribution to the debate in England but its recommendations did not go far enough. An incoming government must work to provide long-term incentives for students from lower socio-economic groups to enter medicine. National efforts to widen access to medical schools must continue to be developed, and national research should be undertaken to look at, and address, the causes of low participation.

**Maintain the cap on student tuition fees in England**

Debt or fear of debt has become a major concern for students and research suggests that this fear deters capable people from applying to university. Under-represented groups may be deterred from entering medicine because of student debt. Average medical student debt on graduation is now approaching £20,000 and this is likely to rise significantly when the first students on top-up fees graduate. The BMA has projected that debt will increase to £37,000 for these students. This is supported by data which show that first-year tuition fee debt is currently up to 50% higher than the first-year debt of those who studied prior to the introduction of top-up fees.

The next government will implement significant changes to student finance, informed by the recommendations of Independent Review of Student Finance in England. Top-up fees continue to be controversial and the first medical students under this new system have not yet graduated. Yet before the impact on student debt is known, proposals have been made to lift the cap. The BMA believes that lifting the cap would have a severe adverse impact on debt especially for those on longer courses such as medicine, and as a consequence, participation in medicine will be badly affected.

**Ensure an equitable and transparent entry system to postgraduate education**

The Foundation Programme refers to the two years of postgraduate medical education immediately following completion of an undergraduate degree in medicine. Medical students need the Foundation Programme application process to be equitable, meritocratic and transparent and subject to independent scrutiny and review. The majority of medical students feel that the current process works well, but change has nonetheless been proposed. Any changes must be made only where it can be shown that they improve the current system. The process should not be used to introduce a ranking system or a national knowledge-based assessment. These are not necessary and would have an adverse impact on medical education. There are already rigorous measures in place to ensure quality and consistency in education and training. A standard single examination cannot measure competency and skills necessary for safe and effective practice as a doctor – being a good doctor is not purely about rote-learning facts.
Medical academics
Medical academics are employed by universities, charities and medical schools to undertake teaching, research and clinical care. They have the primary responsibility for teaching future doctors, but also teach and inspire those whom we rely on for much of the life-long learning that is recognised as best practice in medicine. They play a vital clinical role, providing specialised services direct to patients. They are crucial to the effective functioning of the health care system, as well as contributing significantly to the UK economy.

The BMA calls on all political parties to:
• acknowledge the value of research and education to the nation’s health
• halt the decline in the medical academic workforce
• support medical research
• maintain a balance between patient confidentiality and access to data for medical research.

Acknowledge the value of research and education to the nation’s health
Policy makers and the NHS must acknowledge the immediate and long-term value of education and research to the health of the nation. Clinical academics bridge three worlds: teaching, research, and patient care. Minimising and defusing conflicts between academic and clinical duties should be a priority to allow clinical academics to pursue their professional goals. The principles for achieving this were outlined in the Follett Report, but implementation remains patchy and incomplete. Employers must stop pressurising those involved in academic work to reduce their teaching and research activities.

Halt the decline in the medical academic workforce
In contrast to the increases to the NHS consultant workforce over the last decade, the clinical academic workforce has seen a dramatic decline. Clinical academics are now an ageing group and one in which women remain under-represented at the highest levels, comprising just 11% of academic medicine professors. Medical education has suffered from raids on its funds during times of financial difficulty and may do so again with the worsening financial climate. An improvement in the supply of senior clinical academics, to maintain delivery of education and research, can only be achieved by raising the profile of academic medicine amongst students and by ensuring that there is parity of pay and conditions of service between doctors employed by the NHS and those employed by the universities. The government must continue to provide higher education institutions with the incentives and the necessary resources to achieve this.
Support medical research
Medical academics support increased awareness by patients of the work of medical researchers and opportunities for patients to be involved in medical research. Some of the changes proposed for the NHS, such as the establishment of polyclinics in England, do not take into account the need to support education and research and effectively limit the access of researchers to the patients they need to develop their work. No changes to the provision of health care services should diminish the available opportunities for education and research, which are at the heart of world-class health care.

Patient confidentiality and access to data for medical research
Medical academics are pleased that progress has been made on finding a way forward on allowing medical researchers controlled access to patient records for the purpose of medical research and look forward to continued liaison with an incoming government in order to facilitate advances in medical science while handling sensitive data in a secure way. A balance must be maintained between the interests in safeguarding the confidentiality of patient information and researchers’ controlled access to data in order to continue the medical research for which the UK is so highly regarded.
Securing good health for all members of society will mean coordination across different government departments to ensure policy in one area does not undermine policy in another...
Part three Focus on improving and protecting health

Introduction
Action to improve and protect the health of the nation must remain the priority of an incoming government especially as recession has a negative impact on health. Furthermore, gross health inequalities continue to exist and even widen within the UK and urgent action is necessary to address these concerns. There are intolerable differences in health status between groups in society, and the infrastructure to tackle these problems, both within and outside the NHS, is weak. It is widely known that people living in poverty or those from disadvantaged communities are more likely to experience poor health. The World Health Organisation Commission on Social Determinants of Health recommended that the role of the state should be reinforced in terms of regulating goods and services with a major impact on health such as tobacco, alcohol and nutrition. Doctors and other health professionals play key roles in public health and must play a leading role in the formulation of best practice and strategies for public health. It is vital to continue training doctors in public health. The political parties should be supportive of the Wanless Report’s recommendation that public health professionals in the ‘fully engaged scenario’ should be supported to provide the necessary leadership in devising effective strategies. The parties must therefore support the public health workforce through building appropriate capacity and offering opportunities to develop skills.

The health of the public and population is affected by a whole range of factors in society. Securing good health for all members of society will mean coordination across different government departments to ensure policy in one area does not undermine policy in another. This manifesto outlines key steps as recommended by doctors to attain public health gains. Achieving coordinated working on the ground between health, education, social services, housing and transport policy is a challenge that requires sustained cross-departmental collaboration. An incoming government must make public health policy a coherent and clear national priority. In this manifesto, we touch on alcohol, tobacco, obesity as well as drawing attention to the future health challenges arising from climate change. We also include the need for there to be a public debate on an opt-out system for organ donation.

The BMA calls on the political parties to:
- take strong action to tackle alcohol-related harm
- create a tobacco-free society by 2035
- deal with the obesity crisis and promote exercise
- facilitate an informed public debate on an opt-out system for organ donation
- act decisively on climate change.
Take strong action to tackle alcohol-related harm

Recent years have seen increasing interest in the levels of alcohol misuse in the country, and in particular the pattern of binge drinking and heavy drinking. Alcohol consumption is causally associated with a wide range of medical conditions and is a significant cause of morbidity and premature death in the UK and worldwide. It contributes to a range of acute and chronic health consequences, from alcohol poisoning and injuries resulting from road traffic accidents to cardiovascular disease and several forms of cancer. The more an individual consumes, the greater the risk of harm. Alcohol misuse is associated with crime, violence and anti-social behaviour, and can impact significantly on family and community life. It causes family breakdowns, is a major factor in domestic violence, and ruins job prospects.

The cost of alcohol misuse is substantial, both in terms of direct costs (eg costs to hospital services and the criminal justice service) and indirect costs (eg loss of productivity and the impact on family and social networks). Figures available for England and Wales suggest that the estimated annual cost to society of alcohol-related crime and disorder is between £8 billion and £13 billion, with the costs for health harms estimated at approximately £2.7 billion.33

Doctors are very worried about alcohol consumption among young people and it is a tragedy that doctors are starting to see serious liver disease in young people because of alcohol. Unhealthy patterns of drinking by adolescents are likely to lead to an increased level of addiction and dependence on alcohol in adulthood. Tackling alcohol-related harm should not rely on dependence on voluntary codes operated by the drinks industry.

The BMA calls on the political parties to:

• support increases in alcohol duty above the rate of inflation proportionate to the amount of alcohol in the product
• support minimum price levels for the sale of alcoholic beverages and end irresponsible promotional activities like happy hours and two-for-one offers
• support the display of information on recommended drinking guidelines and health warnings on all alcoholic products, at the point of sale, and in all printed and electronic media
• legislate for a total ban on alcohol advertising in the media
• support reduction in the opening hours of both on- and off-licensed premises
• ensure more funding, training and support to detect and manage people with alcohol misuse problems
• reduce the legal limit for the level of alcohol permitted while driving from 80mg/100ml to no more than 50mg/100ml throughout the UK.
Create a tobacco-free society by 2035
Smoking is a major cause of preventable morbidity and mortality in the UK, with approximately 114,000 deaths every year from smoking-related illnesses, lung cancer, respiratory illness, and heart disease. Smoking disproportionately affects those already disadvantaged by poverty and is a major contributor to health and premature mortality inequalities.

Doctors welcome the steps that have been taken thus far in the UK to halve the prevalence of tobacco consumption but more can be done to protect the health of people from the harmful effects of tobacco. Doctors are supportive of moves towards the development of a comprehensive tobacco strategy to reduce the demand for and supply of tobacco. An incoming government should make efforts to build a tobacco-free society by 2035.

The promotion of a tobacco-free lifestyle that both deglamorises and ‘denormalises’ its use will make a difference to stop young people starting smoking. Most smokers start before the age of 18 and virtually all do so by the time they are 25 years old. Smoking remains the leading cause of preventable ill-health and death in the UK and children will only be truly protected from it when the UK is tobacco-free. Effective policies that will limit young people’s exposure to pro-smoking imagery will prevent a new generation falling victim to tobacco addiction. Support for those who are smokers to quit must also remain a priority as should action to tackle tobacco smuggling and the provision of counterfeit cigarettes.

The BMA calls on the political parties to:
- standardise and increase taxation on all tobacco products at higher than inflation rates
- ensure that smoking cessation services are adequately funded and resourced, and targeted at high-risk groups
- compel outlets selling tobacco to get a licence to do so
- introduce plain packaging on cigarette packets with only the brand name and health warnings
- set minimum price levels for tobacco products
- complete prohibition of the sale of tobacco from vending machines throughout the UK
- implement a sustained population-wide communications programme promoting anti-smoking messages and imagery
- take action to combat tobacco smuggling and trade in counterfeit cigarettes
- recognise that the British Board of Film Classification should take pro-smoking content into consideration for the classification of films, videos and digital material in the UK. This should consider whether the depiction of smoking is condoned, encouraged or glamorised in the absence of editorial justification.
Deal with the obesity crisis and promote exercise

Priority must be given to tackle the UK’s obesity crisis and this can be done through targeting childhood obesity. Childhood obesity rates in the UK are soaring. This is extremely worrying as obesity can cause heart disease, osteoarthritis and some cancers. There is a responsibility on individuals to take action to halt this obesity crisis, and also on policy makers to provide an environment that assists individuals in making appropriate choices.

Accurate food labelling and clear information is imperative to encourage the public to make informed choices about their diet. Nutritional labelling must be clear, simple and easy to understand. Health claims made on food must also be addressed. Both nutritional and content claims on labels, and functional claims on packaging and in advertising, must be accurate and verifiable. Research into the dietary knowledge of adolescents aged 14 to 16 years found that they did not tend to check nutritional labelling or weigh up the nutritional content of food that they chose.  

Physical activity is essential for good health at all ages. As a key determinant of energy expenditure, physical activity alongside a healthy diet is fundamental to energy balance and weight control. It has a range of benefits during childhood, including healthy growth and development, maintenance of energy balance, psychological wellbeing, social interaction and reduction of risk factors such as hypertension and high cholesterol. Real action is needed to ensure that there is support and access to sport and recreation facilities within schools and communities. Walking and cycling in daily activity should be a public health priority.

Focusing on promoting both a healthy diet and moderate lifelong exercise together, and not in isolation, will lead to real change.
FOCUS ON IMPROVING AND PROTECTING HEALTH

The BMA calls on the political parties to:
- ensure that the food and drink industry implement a standardised, consistent approach to food labelling based upon the traffic-light front-of-pack labelling recommended by the Food Standards Agency (FSA). Labelling should also include Guideline Daily Amount (GDA) information
- legislate for a ban on the advertising of unhealthy foodstuffs, including inappropriate sponsorship programmes, targeted at school children
- make more extensive use of the media, including children’s programming, to promote healthy lifestyle messages that make such lifestyles both fun and aspirational

- introduce a legal obligation to reduce salt, sugar and fat in pre-prepared meals, and mandatory nutrient and compositional standards for school meals
- develop a strategy to encourage children and young people to take part in regular exercise
- increase and protect access to recreational facilities (eg public swimming pools and playing fields) regardless of socio-economic status and level of physical and psychological ability
- promote active travel networks by providing safe environments for pedestrians and cyclists and ensuring that there is appropriate support of the built environment by local and central government. Furthermore, there should be increased provision of facilities for the combination of cycling with rail and other travel.
Facilitate an informed public debate on an opt-out system for organ donation

Each year around 1,000 people die waiting for an organ transplant — many of these deaths could be avoided by strategies to increase the availability of donor organs. Although repeated surveys have found that between 70% and 90% of the population say they support organ donation, only 27% have made their wishes known by signing up to the NHS Organ Donor Register. Where relatives are asked for consent at this most difficult time, nearly 40% opt for the default position, which is not to donate.

Changing the default position in support of donation, by introducing an opt-out system, would maximise donation from willing individuals while providing additional protection for those who do not wish to donate organs after their death. There is growing evidence from other countries that a presumed consent (or opt-out) system is one of a number of factors that can lead to increased donation rates.

Such a shift must have public support. Surveys undertaken to date show around 64% of the public would support an opt-out system but we need to have more public debate. Doctors welcome and support the current efforts to improve the infrastructure of donation through increased funding and better organisation. The Organ Donation Taskforce has predicted that these changes could lead to a 50% increase in donation rates by 2013 but only time will tell whether that is achievable. Even if donation rates improve at this level, there will still be a waiting list and patients will still be dying. Introducing an opt-out system following an informed public debate and with appropriate safeguards, alongside these other improvements, would maximise the number of lives that can be saved and transformed by transplant.

The BMA calls on the political parties to:
• continue to invest in a well-funded and well-organised system for organ donation
• at the same time, facilitate an informed public debate about a shift to an opt-out system for organ donation (presumed consent).
FOCUS ON IMPROVING AND PROTECTING HEALTH

Act decisively on climate change
Climate change is the biggest environmental concern facing the world today. Climate change is expected to have consequences on economic development, food production, access to water, migration patterns and has the potential to affect transmission patterns of communicable diseases. Rapid population growth, increased levels of consumerism and materialistic lifestyles in the developed world and a declining natural resource base are all putting a strain on the planet and are exacerbating and contributing to the effects of climate change.

Rising temperatures, changing sea levels, and extreme weather patterns, are a major threat to public health. While many of these factors will affect other countries more than the UK, we will not be immune from them. The UK needs to be better placed to tackle the growing health challenges posed by climate change.

The NHS is the largest single organisation in the UK with an annual purchasing budget of around £17 billion. It employs 1.5 million people and emits around 1 million tonnes of carbon every year. There is huge potential for this employer to promote combating climate change. It is essential that when new hospitals, GP surgeries and other premises are being built, the NHS learns from best practice construction projects.

The BMA calls on the political parties to:
- act decisively and quickly to introduce effective action on climate change
- develop binding and enforceable carbon footprint reduction guidelines for the NHS
- promote energy efficiency
- support initiatives to promote the health co-benefits of actions aimed to mitigate climate change (eg reducing car use will equate to a reduction in CO2 emissions, result in increased levels of physical activity and could also lead to a reduction in accidents through safer roads and public spaces)
- regularly review the evidence on mitigation and adaptation policies (such as greening public spaces) and implement those that will make a difference to the UK and increase or contribute to global sustainability.

The NHS is the largest single organisation in the UK... There is huge potential for this employer to promote combating climate change...
References


4. UK Family Health Services (FHS) refers to General Pharmaceutical (GPS), General Medical (GMS), General Dental (GDS) and General Ophthalmic (GOS) Services. The FHS are provided in the community by family practitioners: general medical practitioners (GPs), dentists, pharmacists and opticians.

5. NHS data on the volumes of medicines used and issued in NHS hospitals in England are not available.
   http://www.ic.nhs.uk/services/prescribing-support-unit-psu/psu-services/hospital-database


   https://www.statswales.wales.gov.uk/TableViewer/tableView.aspx?ReportId=1373 (Wales=1,060,038),
   http://www.isdscotland.org/isd/4024.html (Scotland= 1,509,324) and


10. OECD Health Data. All procedures; in patient plus day cases, extracted from OECD database on 28 September 2009 (data for 2007; 9,653,720/365 days)

11. The sum of all types of surgical interventions (invasive) performed as in-patient cases and day cases. Only the main procedure performed on a patient during a hospital stay would normally be reported.

12. OECD Health Data. In patient procedures, extracted from OECD database on 28 September 2009 (data for 2007; 4,408,361/365 days)

13. Patients who are given invasive surgical treatment, whether on an emergency or elective basis, and who stay over at least one night in an in-patient institution.
REFERENCES

14 OECD Health Data. All procedures; Day cases, extracted from OECD database on 28th September 2009 (data for 2007; 5,245,359 / 365 days

15 Patients who are given invasive surgical treatment (elective surgeries only) which are carried out in a dedicated surgical unit or part of a hospital and which lead to discharge on the day of the operation.


18 The purchaser-provider split takes a very different form today than when originally conceived in the early 1990s. The move that originally established the internal market in the NHS was the introduction of a new funding system that ended the direct financing of all hospitals/providers and instead allocated funding to Health Authorities who then selectively purchased care from hospitals through large, block contracts. Although both the specific arrangements and terminology have moved on since then, the purchaser-provider split and internal market still prevails today, taking the form of PCT commissioners who, within an allocated budget, purchase care from providers, such as hospitals, using the relatively new national tariff under the system of payment by results (PbR). GPs are involved in PCT commissioning through practice based commissioning (PBC). Whilst PCTs hold the budget and remain responsible for contracting with all providers, GP practices are expected to manage their indicative budget within the annual cycle and either not exceed it or, ideally, spend under it.

19 The European Working Time Directive (EWTD) limits doctors' working hours. It is European Union legislation and is enshrined in UK law as the Working Time Regulations 1998 (WTR). The WTR have applied in full to most workers, including all employed doctors other than those in the training grades, since 1 October 1998. On 1 August 2004, the WTR working hours limits began to be phased in for doctors in training, beginning with a 58-hour average weekly limit, reducing to 56 hours on 1 August 2007. Rest requirements for junior doctors have been in effect since 1 August 2004. On 1 August 2009, the maximum number of hours that a junior doctor can work decreased from 56 to 48 hours per week.

20 Revalidation is the process by which doctors will, in future, demonstrate to the General Medical Council (GMC) on a regular basis that they remain up to date and fit to practise.

21 See the 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

22 A fundamental part of the new 2004 GP contract was the Quality and Outcomes Framework (QOF). This framework created a system which remunerated general practices for providing quality care to their patients, funding which could be used to fund further improvements to the quality of health care delivered in the practice. Linking resources with the QOF ensures that the work undertaken in general practice is adequately resourced, standards are consistent across the country, and practices achievements are recognised.

23 A substantial part of a practice's basic income comes in the form of the Global Sum (GS). This amount is calculated using a formula which takes into account the characteristics of the registered patients. However, applying the formula to the whole GS leads to a significant variation in the amounts given to practices and fails to recognise the basic costs of running a practice sufficiently. Apportioning an element of GS through simple capitation would go someway to resolve this problem and provide greater support for growing practices.

24 The Cost Rent Scheme's purpose was to reimburse the cost of finance for providing new or considerably modified GP premises.

25 BMA Student Finance Survey 2009
26 The Panel on Fair Access to the Professions was established by the Prime Minister in 2009 following the New Opportunities White Paper. The Panel was led by Rt Hon Alan Milburn MP and investigated barriers and pathways to entering the professions. More information is available here: http://www.cabinetoffice.gov.uk/strategy/work_areas/accessprofessions.aspx
28 BMA Student Finance Survey 2009
32 In the ‘fully engaged’ scenario the level of public engagement in relation to health is high, life expectancy goes beyond current forecasts, health status improves dramatically, use of resources is more efficient and the health service is responsive with high rates of technology uptake. HM Treasury, Securing good health for the whole population (2004) http://www.hm-treasury.gov.uk/d/Wanless04_summary.pdf
37 NHS Blood and Transplant. Organ and tissue donation – your questions answered (http://www.uktransplant.org.uk/ukt/how_to_become_a_donor/questions/questions.jsp)
38 NHS Blood and Transplant – www.uktransplant.org.uk
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