BMA

Funding priorities for the health and care sector: BMA's submission to the Autumn Budget 2024

1. Introduction

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.

This submission sets out the BMA's funding priorities over the next financial year and beyond. Overall investment into the Department of Health and Social Care to increase NHS funding is needed (section 2), particularly to increase GP funding (section 3), to fund staff pay increases (section 4), and to improve infrastructure (section 7). In addition, further attention must be paid to financial disincentives penalising doctors from working full time – pensions and childcare (section 5) - and to improving the medical training pipeline (section 6). Finally, there must also be investment into public health (section 8).

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 in the devolved nations, supported by the release of the required consequential funding.

2. The health and care system is under significant pressure and overall investment must be increased

The BMA agrees with the Government's assessment that the health and care system is broken. Underinvestment over the past fifteen years has meant that staff including doctors have been bearing the brunt of keeping patients safe in a broken service – a status quo they are no longer willing to tolerate. Fixing it will require investment, but that is investment that will lead to future dividends for the UK population and the UK economy.

The health and care system is facing considerable challenges, but we share the new Government's ambitions to get the NHS back on its feet. Over the past fifteen years, underinvestment and a lack of long-term thinking has meant that the NHS is no longer providing an effective service for many, with waiting lists hitting unprecedented highs and many patients struggling to even see their GP. We recognise that due to predetermined Government decisions around taxes and fiscal rules, public

finances are tight and there are difficult decisions to be made. However, a lack of investment in the NHS has had significant knock-on effects for economic growth and is therefore also impacting public finances. There were 7.6 million pending elective treatments in June 2024 (6.4 million unique patients). The number of people waiting over 18 weeks for elective treatment stood at 3.13 million in June 2024 – representing 41% of patients on the waiting list. This underperformance of the NHS has significant knock-on effects on the economy and the public purse, as many people are unable to work whilst sick. IPPR estimated in 2023 that the economic benefit of bringing down the waiting list would be £73 billion from 2023-27, as it would allow more people to go back to work/work longer hours, as well as enabling them to take part in tasks which have a social benefit such as volunteering and caring for family members. As such, investing in the NHS to bring down the waiting lists and ensure it provides timely care for those that need it, is an investment in the economy and future sustainability of public finances. Millions of patients are still waiting too long to receive the care they need. The BMA welcomes the Government's focus on elective recovery but plans to cut the backlog need to be backed by staff. The BMA has concerns that an expectation that staff will deliver 40,000 additional appointments in evenings and weekends for time and a half pay will not be sufficiently attractive to incentivise already overworked staff.

Real terms spending growth in the health and care system since 2009/10 has been significantly below historical averages. As the Health Foundation calculate, average real terms growth in the DHSC budget under the Coalition government (2009/10 -2014/15) was 1.1% year on year; real terms average growth in the Cameron and May Conservative governments (2014/15 - 2019/20) was 2.6% year on year and even taking into account COVID pressures, real terms average growth in the most recent Johnson, Truss and Sunak Conservative governments (2019/20 – 2024/25) is expected to be 3.0% year on year. This is in sharp contrast to the Blair and Brown Labour governments (1996/97 – 2009/10) where average year on year real terms growth was 6.7%. The long-term real terms average growth for the DHSC budget stands at 3.8% year on year. The health system in the UK, like in many other countries, is under consistent pressure from the increasing need of population growth, an ageing population with increasingly complex healthcare needs, and increases in the relative costs of treatments including drug prices – which is why it is vital that provision keeps up with need.

These real-terms funding cuts have left NHS secondary care services under extreme financial pressure. Trusts are facing large financial deficits and are being required to make financial savings that are adversely impacting patient care. There are over 130,000 staff vacancies across the NHS but due to the financial pressures, many secondary care trusts have imposed recruitment freezes and even voluntary redundancy programmes. A recent survey by NHS providers found that more than half of trust leaders were extremely concerned about delivering operational priorities within their 2024/25 financial budget, with over 92% of them stating that the financial challenge facing them was greater than in 2023/24. Less than 1/3rd of respondents were confident that their system will deliver its recovery targets for physical health services and only 8% were confident that they would improve the waiting time for mental health services. Less than half felt that their trust would meet the new waiting time target of 78% of A&E attendances being seen within 4 hours – a target that was set at 95% under the last Labour government. Emergency departments are under severe pressure and suffering from crowding. Crowding has a direct impact on patient mortality and poor

patient outcomes[1,2]. It also creates inefficiency in the delivery of care as well as increasing the rates of stress and burnout amongst staff.

ED crowding is a function of a failure across the health and social care system. The NHS has one third of the number of hospital beds compared to Germany and crowding results from there being an insufficient number of beds within the system for patients who require admission (see also section 7). The Royal College of emergency medicine recommends that bed occupancy in hospitals that admit emergency patients should be no more than 85% and the BMA supports that recommendation. It is essential that there is additional investment in secondary care, beyond that required to cut waiting lists, to ensure that critical patient services can be delivered sustainably.

There are significant opportunities for increased efficiency and productivity in the NHS. A more efficient and effective NHS is the collective goal of the Government and those who work in the NHS. However, productivity gains can only be realised if they are sustainable and underpinned by sufficient funding. Poor healthcare estates, including mental health settings, and inadequate or malfunctioning IT systems and equipment have a direct impact on the health, safety and wellbeing of staff and patients, as well as adversely affecting efficiency e.g. when patients have to be seen in corridors because there is no space on wards. The NHS must receive the investment it needs in order for staff to be able to work effectively which means there is a need for investment in technology, infrastructure and to fix the maintenance backlog.

Public investment, for example in NHS infrastructure, will lead to economic growth. The OBR recently estimated that a 1% GDP increase in public investment would likely increase the level of potential output by 2.5% in the long-run (over 50 years) – a vital investment needed to allow for increased public revenue to fund future healthcare need.

Attempts to cut funding in previous financial years have been counter-productive, and funding pressures have meant that funding earmarked for capital improvements, vital to long-term productivity improvements and future financial stability, has had to be reallocated from capital budgets to top up day to day spending.

Therefore, the BMA is calling for real terms increases to both resource and capital health budgets. The day-to-day budget for the DHSC in 2025/26 should increase at least in line with the previous Labour Government historical average of total real terms funding growth of 6.7%. This would mean an increase to the total budget of £13.25bn in current prices,[3] which would allow for making a start on the priorities set out in the rest of this representation, including investment in primary care, mental health and public health, investment in vital public capital, and continuing the journey towards valuing doctors and stemming the flow of doctors leaving the profession, with pay restoration. Going forwards, beyond next year, budgets should be set on a multi-year basis to allow forward planning – it is hoped that growth will not need to be as high in future years after the system has 'caught up' slightly for the past years of underfunding.

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[1] Moulton C, Mann C, Emergency Medicine. GIRFT National Program Speciality Report. 2021. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2022/08/Emergency-Medicine-Apr22q.pdf

[2] Jones S, Moulton C, Swift S, et al. Association between delays to patient admission from the emergency department and all-cause 30-day mortality. Emergency Medicine Journal 2022;39:168-173.

[3] This is calculated using 6.7% real-terms increase for DHSC TDEL budget, applied to planned 24/25 DHSC TDEL budget as set out in 2024 PESA using ONS GDP deflators published June 2024.

3. There must be increased investment in General Practice, benefitting the entire health system

General Practice is a vital part of the healthcare system and provides excellent productivity and value for money. Research has found that every pound spent on primary or community care correlates with up to a £14 increase in economic activity, which is a considerably higher return compared to investment in other care sectors. This Government has clearly highlighted the importance and need to focus on primary care and General Practice in its election manifesto.

Investment into the core GP contact has not kept up with increasing cost pressures faced by practices in recent years. The value of the contract – which pays practices for providing essential services – has declined by 3.6%, or £358mn, in real terms since 2018/19, [4] despite the 2024/25 DDRB award resulting in a nominal additional £312mn uplift to the contract.

This is putting a considerable strain on service delivery and will jeopardise plans to prioritise General Practice if allowed to continue. [5] Practices unable to cover rising expenses are being forced, for example, to reduce their staff numbers.[6] Some practices are unable to afford much-needed locums, fuelling locum unemployment whilst patients too often struggle to get a timely appointment.[7] Some practices have also been unable to offer staff pay rises that keep up with inflation or even fulfil government commitments, resulting in reduced morale and retention issues which ultimately impact services provided to patients. Some practices have even been forced to close or merge: between 2013 and 2023, the number of general practices fell by 20%.

At the same time, demand continues to increase. A single full-time GP is now responsible for an average of 2,291 patients, which is 354 more than in September 2015. The increasing workload in General Practice is unsafe for patients as well as staff, and forces some GPs to reduce their hours or quit the profession altogether.[8] This further depletes the GP workforce, resulting in a vicious cycle.

For 2025/26, **the BMA is therefore calling for additional investment in the GP core contract** for:

- Practices – to stabilise vulnerable practices and prevent further surgery closures;
- Patients – to sustain general medical services across the NHS and protect patient services being delivered closer to home;
- the electorate – to signal a commitment to 'bring back the family doctor' and shift greater resource into primary medical services as committed in the Government's election manifesto.

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[4] As measured by CPI. Although the BMA's preferred measure of inflation is RPI, CPI has been used for the GP practice contract as agreed with NHSE.
[5] In the BMA's Practice Finance Survey (December 2023), over half of responding practices (57%) reported cashflow challenges in 2023 that affected their practice operationally.
[6] The BMA's Practice Finance survey (December 2023) found that 63% of responding practices had either stopped recruitment for new or existing roles, or were considering doing so, due to cost pressures. Similarly, 17% had to make staff redundant, or were considering doing so.
[7] The latest GP Patient Survey (2024) suggests 34% of patients felt they had to wait too long to obtain an appointment with their practice.
[8] The BMA's GP Vision survey (January 2024) showed that 77% of respondents reported that their work has a detrimental impact on their quality of life, and 91% said that workload intensity might push them away from working as an NHS GP.

We have modelled a requirement for **GP practice core funding to increase by at least £40 per weighted registered patient**, i.e. at least £2.5bn overall, which reflects a mere c1.5% of current NHS expenditure.

In addition, there must be **a commitment to determining longer-term general practice investment plans in the forthcoming Comprehensive Spending Review (CSR) and the refresh of the NHS Long Term Plan (LTP). Patients deserve a new GP contract for England**, which would commit to a minimum general practice investment standard that protects neighbourhood services and the delivery of out-of-hospital care led by expert generalists who know their patients and provide continuity of care for years to come.

A new contract will require a transformative approach: Treasury and DHSC must focus on value for money and productivity within our NHS. **A minimum investment standard should be determined alongside fair annual funding increases to the GP core contract.** It must recognise population growth, inflation, and provide patients with GPs and practices that have the opportunity to deliver efficient, high quality and safe preventative and long-term expert generalist-led continuity of care.

A significant increase in NHS resource will need to be invested in primary medical services in a new national contract, which will ensure General Practice is on the road to recovery, better equipped to meet patient demand, expand its services, and secure the workforce needed to improve patient outcomes, reduce system workload, and mitigate for the high cost of avoidable care episodes. This, in turn, will incur cost savings across the health system, as patients will require fewer practice appointments and fewer costly referrals or unplanned urgent or emergency attendances to secondary, tertiary and other community care services.

The profession is serious about its efforts to make general practice the best possible service it can be, and has instructed the BMA to help it take collective action. There is therefore considerable urgency to reversing the damage successive governments have done by underfunding general practice for so many years. The BMA remains ready to work constructively with DHSC and NHSE to deliver such increased investment. DHSC and NHSE therefore need Treasury backing to give the profession and patients safety, stability and hope, and ultimately deliver the continuity of care we all wish to see via a new well-funded national GP contract. Investment now will reap long-term benefits and savings in the years and decades to come.

4. Financial disincentives to work – pensions and free childcare – must be fixed

Alongside pay which is crucial and must continue to improve (see section 5), the Treasury should focus on other elements of the tax and benefits system that impacts doctors' financial incentives to work. No doctor should be discouraged from working the maximum number of hours they want to as a result of poorly designed financial incentives, especially given how high waiting lists are. No doctor should be in the position where they are effectively paying to work. Two key issues causing this are the impact of pension taxation and the personal allowance and childcare benefit tapers.

Pensions

The main priorities regarding pension taxation are retaining the Lifetime Allowance abolition, indexation of the Annual Allowance threshold and a solution for the unfair interaction between the Annual Allowance taper and the NHS Defined Benefit pension scheme. The BMA is also concerned

that some ideas such as flat rate pension tax and taxes on pension lump sums would disincentivise doctors to work and jeopardise the Government's elective recovery plans. Any detrimental changes to the treatment of tax-free lumps is also likely to trigger an increase in early retirements. The BMA would welcome a meeting with the Treasury to discuss these issues further.

Elective recovery plans could be undermined if these disincentives are not removed. Current plans to tackle waiting lists, eliminate backlogs and restore the 18-week elective care standard hinge on doctors – and consultants in particular – undertaking additional shifts. If these disincentives remain in place, many of those senior doctors will be reluctant to accept additional work out of concern it could negatively impact their pensions and tax arrangements. This would be an unsatisfactory outcome for all parties and one that could risk slowing down essential efforts to restore elective services.

Lifetime Allowance

The removal and abolition of the lifetime allowance (LTA) and the increase in the annual allowance (AA) announced in the Spring Budget 2023 by the previous Government were welcome, although this was not the BMA's recommended solution to the NHS pension taxation crisis, which left thousands of doctors with little option but to reduce their hours, or to retire early. In response to the Spring 2023 Budget reforms, 37.0% of respondents to a BMA survey said they decided to retire later than previously and 28.4% said they increased their (pensionable) work[9]. This suggests these reforms helped to increase NHS capacity by removing the obligation from the vast majority of doctors of paying punitive pension taxation bills. We were pleased that the Labour Party did not include plans to reintroduce the LTA in their manifesto and has not announced any such plans since forming the new Government. Such a move, especially without guarantees about how public sector workers would be protected, would cause a large number of senior doctors to retire early at the very time when the nation needs their expertise most – severely endangering not just manifesto commitments on reducing waiting lists, but likely leading waiting lists to grow further.

Annual Allowance

However, the design of the Annual Allowance tax charge and its interaction with the Defined Benefit (DB) pension scheme still means more senior doctors may reduce their hours worked or reject senior responsibilities in order to avoid financial penalisation. Although the above changes partially removed the perverse incentive pushing doctors to retire early, they didn't resolve the problem with pension taxation entirely, as the design of the AA and in particular the tapered AA have not been meaningfully reformed. **Therefore, it is vital that the LTA remains abolished, alongside reforms to the AA and tapered AA.**

The increase to the AA in 2023 by the previous Government, while welcome, is not a long-term fix, as there has been no assurance that the AA will be indexed to inflation. The Annual Allowance threshold must be indexed to inflation going forwards. Indeed, a year has already passed without any further increase to the AA, despite prices and pay rising. It is essential that the AA limits are kept under review to ensure their value is not eroded in real terms, otherwise the NHS will find itself in a growing pension taxation crisis with the risk of losing many of its experienced doctors at a time when it can least afford it.

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[9] BMA June 2024 snap pension taxation survey

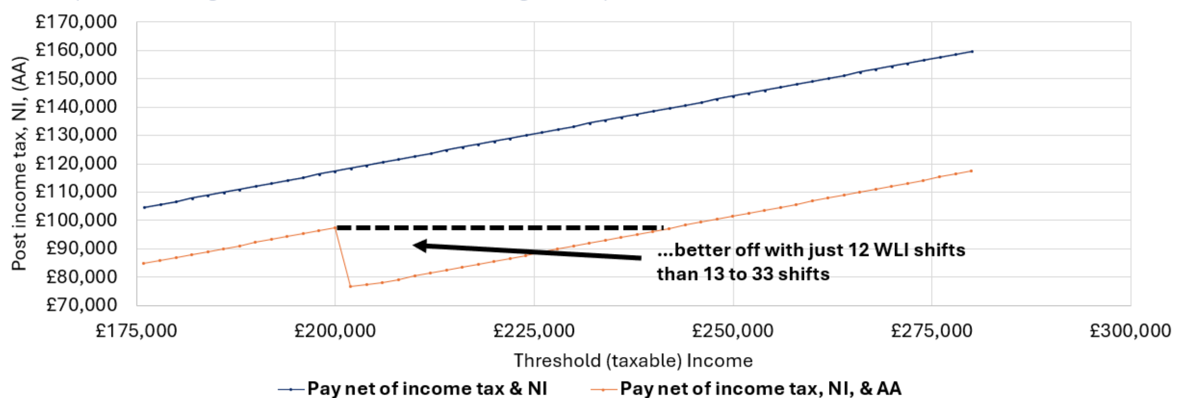
Annual Allowance taper

The changes made by the previous Government did not address the impact of the tapered AA. The tapered annual allowance was not meaningfully reformed by the last Government, as although the adjusted income level (threshold income plus deemed pension growth) was increased from £240,000 to £260,000, the threshold income that applies for the taper has not changed and remains at £200,000. Indeed, this level has been frozen since 2020. Prior to the threshold income being increased in 2020, we saw senior doctors having to reduce their hours on an unprecedented scale and this is once again becoming a significant issue, given that the effective value of this has fallen in real terms.

Under current tax rules, crossing the tapered AA "threshold income" even by £1 can result in very significant financial penalties - with additional tax charges of up to £22,500. Doctors who exceed the threshold income usually do so on the basis of taking on additional work that is non-pensionable. Therefore, this additional tax charge is not related to any additional pensionable benefit. Indeed, if scheme pays is used to pay this tax charge, the amount of pension will fall because of taking on this extra work. Consequently, if members exceed this earnings threshold, they will be faced with the option of either paying this tax charge from their post-tax pay or permanently reducing the value of pension they will receive in retirement. Furthermore, the amount of additional tax will typically be higher than any income gained from the work itself – they are effectively paying to work. The best way to avoid this is by reducing hours or refusing to take on additional work in order to keep taxable pay below the threshold income limit. For example, in the illustration below, the hypothetical doctor would be financially better off keeping their "threshold (taxable) income" this year slightly under the £200,000 threshold income limit, unless they earn about £242,500 or more, after accounting for the AA tax charge. For example, this could equate to paying to work to undertake up to 21 waiting list initiative (WLI) 10-hour weekend shifts at £2,000 per shift.

Significant incentives for some senior doctors affected by the Annual Allowance to avoid extra/reduce current work in 2024/25

Estimated post-tax earnings after income tax, NI, and AA charge. Same pension at all incomes.



Source: BMA analysis based on actual Consultant (2003) England pay scales and 2024/25 tax & NHS pension rules. Hypothetical mid-career full-time consultant works only in NHS, has 23 years' service in 1995 pension scheme (after 'McCloud' rollback) & increments to top of pay scale in 2024/25. **Pensionable pay at all incomes is top of scale full-time basic pay, a medium (5%) on-call availability supplement & Level 6 Pre-2018 LCEA, which means pension benefits accrued do not vary.** All incomes also include 2 contractual additional programmed activities. What varies is other non-pensionable pay (e.g. waiting list initiatives, illustrated at £2,000 per 10-hour weekend shift. 0-52 shifts shown. AA tax charges vary by personal circumstances. Where pension growth is large due to increments, **additional AA tax charge may be up to £22,500 by going £1 over £200k taxable pay. Doctors should never #PayToWork.** Chart inspired by Institute for Fiscal Studies analysis of different tax cliff in Changes and challenges in childcare report (March 2023).

A further consequence of the operation of the tapered annual allowance is its impact on those who may choose to retire and return. This group, once they combine their pension (which is

taxable) and taxable retire and return earnings, will be left perilously close to the "threshold income" limit of £200k. This may provide a further serious disincentive to do additional work due to the highly punitive nature of the tapered annual allowance - providing a "tax cliff" that a member may trip over even with a single shift. It is this issue that caused many to reduce hours and retire early when the tapered annual allowance was introduced.

The spectre of the tapered AA continues to present a significant barrier to NHS capacity, especially following recent, albeit crucial in the fact of sustained pay erosion, above inflation pay rises for some doctors. In a snap survey on pension taxation in June 2024, over 5,600 BMA members from across the UK made clear that the punitive tapered annual allowance presents a serious risk to the Labour Government's goal to deliver an extra 40,000 appointments through extra weekend and evening working. More than 7 in 10 (71.1%) of all respondents indicated that if there were no further reforms to the tapered annual allowance following the general election, this will prevent or limit their ability to take on additional overtime. Amongst consultant respondents, this proportion rose to 77.1%.

Options for fixing the AA taper disincentive to work include scrapping the tapered AA or reintroducing the Annual Allowance Compensation scheme. The BMA believe that to maximise NHS capacity, the tapered annual allowance should be scrapped to remove this tax cliff.

An alternative would be to introduce an Annual Allowance Compensation scheme for those working in the NHS and doctors employed in other public sectors. In 2019/20, the NHS in England and Wales introduced an 'employer based' compensation scheme to reimburse staff for annual allowance charges. If Annual Allowance limits continue to be reduced in real terms, a cost-effective solution would be to run a similar scheme annually. It would be essential that this applied across the UK and was available to all of those working in the NHS (as well as doctors in other public sectors such as universities, local authorities and armed forces), that are adversely impacted by pension taxation.

As a minimum, the level of the threshold income could be increased given that it has been frozen since 2020 with a commitment that this would rise with inflation going forward. However, this would not be a complete solution as the "tax cliff" would remain a problem for some doctors and its presence would continue to alter the behaviours for others, even if they were not at risk of crossing the threshold income.

The BMA has previously said that our preferred solution would have been to remove the annual allowance from public sector defined benefit schemes. As we have presented to you previously, this would be the most cost-effective and simplest solution. It would also address this issue for the long-term. For the vast majority of people in the NHS, pension growth is already limited by nationally agreed pay awards and tax relief is already significantly addressed by contribution tiering, which is the steepest in the public sector and does not exist outside of the public sector. However, any other proposals that would protect doctors from punitive taxation measures for working longer hours for the NHS would be welcomed by the BMA and our members. These may include our proposed solution around a compensation scheme that was guaranteed to apply to all doctors across the four nations. Finally, another option would be to scrap the annual allowance taper and index the annual allowance to inflation, but this would not be a complete solution to the issues doctors face.

Whichever solution is agreed upon, there must be parity across the UK and for doctors in non-NHS schemes. There are three separate NHS pension schemes across the UK, with significant numbers of doctors working in the NHS who are members of non-NHS schemes. It is essential that any solutions apply equally to all affected staff.

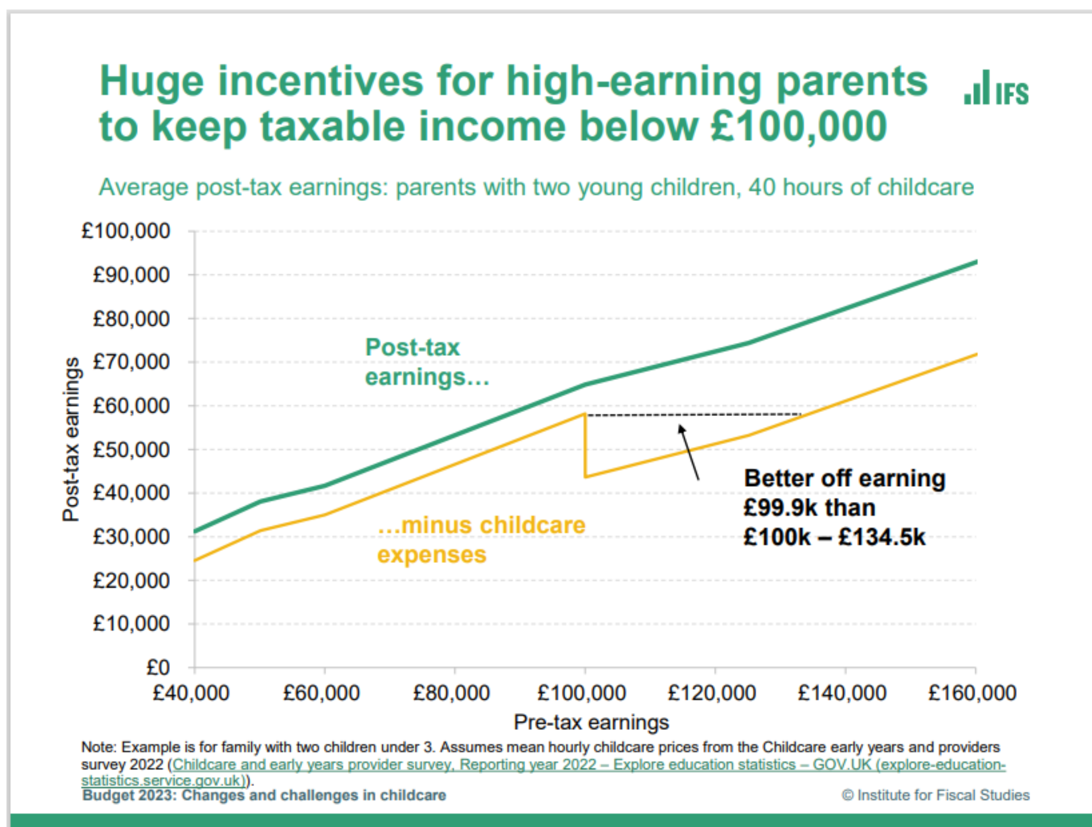
Flat rate pension tax relief

The BMA and our membership are concerned about media speculation regarding introducing a flat rate of tax relief on pension contributions and possible changes to tax free lump sums that may be under consideration by Government. In the context of the tiered contribution defined benefit scheme in the NHS, any further detrimental changes that may exacerbate punitive pension taxation is likely to have an adverse impact on the workforce. Pension savings are considered over a long-term horizon and people require certainty when making their financial plans for retirement. The feedback we have been receiving from members is that any detrimental changes are likely to result in significant numbers retiring early. It is essential the BMA discusses plans with the Treasury in order to ensure that there are no accidental adverse consequences to any suggested changes.

Childcare

Senior consultants, SAS doctors and GPs with childcare responsibilities face extremely high marginal tax rates due to the loss of free childcare hours and tax-free childcare. Tax free childcare and 30 hours free childcare were introduced in 2017 with the goal of helping working parents pay for childcare. Unfortunately, the eligibility threshold meaning that any individual earning over £100,000 did not qualify, created a cliff edge for high income parents making them face extremely high effective marginal tax rates for earning over that amount. Doctors can even be left financially worse off if the cost of the lost childcare exceeds the increase in their take-home pay. We note analysis by the IFS from last year that illustrates this principle for taxpayers generally, reproduced here with permission. The BMA is calling for the eligibility threshold to be removed.

We have evidence that doctors are reducing their hours because of this threshold. A recent BMA (July 2024) survey on the financial impact of childcare on doctors, multiple doctors gave us testimonials of how they have reduced their hours due to the childcare eligibility threshold, to ensure that they were not worse off, including those in key areas of focus for the government (cancer care; and psychiatry).



In addition, the BMA believes that since the High Income Child Benefit Charge threshold has failed to even keep pace with inflation, it is no longer fit for purpose and should be further reviewed. At introduction in 2013, this charge was due once you earn at least £50,000. Whilst welcome that this threshold was increased by the last Government to £60,000 and the rate of the charge halved from April 2024, the threshold has failed to keep pace with inflation. The BMA is calling for the threshold to be restored to the level it would be had it been uprated year-on-year by September CPI (as other benefits are) every April since 2014 – this would mean it would increase from the current level of £60,000 to £68,461 in the current financial year, and then indexed to inflation going forwards.

5. To better retain doctors and avoid industrial action, pay must continue to improve alongside working conditions

A rising number of doctors are leaving the NHS. Though some doctors leave to retire, or for other unavoidable reasons, too many doctors leave the NHS early. NHS Digital data shows a growing number of doctors citing largely preventable reasons for leaving NHS organisations, including health concerns, work-life balance, working relationships and their reward package. The BMA estimates that between 15,000 and 23,000 doctors left the NHS prematurely in England between September 2022 and September 2023.[10] As well as the loss of doctors with experience built up over years in the health service – with knock on impacts for care quality, health service productivity and the ability to train the future generation of doctors – this is slowing the rate of workforce growth. Between March 2023 to March 2024, for every 10 Hospital and Community Health Services (HCHS) doctors that joined an NHS organisation, around 7 doctors left. Extra recruitment, without tackling high levels of

[10] BMA report: Tackling medical attrition in the UK's health services

preventable attrition, is an inefficient and costly solution to the NHS's workforce problem. The BMA estimates that medical attrition cost NHS employers and the public purse a minimum of between £1.6 and £2.4 billion in 2022/23.

Without action, in the time it takes to train a doctor – a minimum of ten years for a GP, or 11 for a consultant, for example – doctors will continue to leave the health service. For every doctor that leaves, pressures worsen for those who stay – increasing the likelihood that they too will vote with their feet and leave. And there are signs that more doctors are going to leave in the future, representing a rising cost to the public purse. The GMC report that 16% doctors in the UK in the 2023, and 15% in 2022, have taken 'hard steps' to leave, compared to 7% in 2021. [11]

A significant issue leading to doctor stress and desire to leave is pay. Over the last decade and a half, doctor pay has been cut significantly in real terms. Doctors have faced much larger real terms pay cuts than other workers in the economy and compared to other staff groups in the NHS. Doctors' pay has been progressively eroded over time, reaching a peak of over 30% real-terms decline in pay in 2022/23 since 2008/09, and a 2022 BMA survey showed that 45% of Resident doctors, highly trained professionals, struggled to pay their rent or mortgage, and 50.6% struggled to pay utility bills. Doctor pay is no longer commensurate with the skills and experience of doctors, compared to other highly qualified workers in the economy. As the DDRB points out, in their most recent (2024) report, earnings for doctors lag "behind some market comparators" such as legal, financial and pharmaceutical professionals. The recent pay scale reform offer only goes part of the way towards rectifying this. Doctors are also seeing better pay and conditions available elsewhere, for example in Australia, Canada, Ireland and the Middle East.[12] As long as pay and conditions in the NHS remain inferior to other comparable nations, there is a significant risk of doctors leaving and to this Government achieving its manifesto commitments on waiting lists.

Many doctors have significant student debt, but despite this are paid less than less skilled staff at the start of their career. Newly qualified doctors may have £100k of student debt or more, but then find themselves paid less than other colleagues on their team with lower levels of training, skills and experience. The latest DDRB recommendations for 2024/25 put the pay of FY1 doctors up to around £10,000 short of a Physician Associate's pay on band 7 of the agenda for change pay scales. Both debt and this adverse pay differential need addressing urgently.

Poor working conditions also contribute to decisions to leave the health service. Persistent staff shortages mean excessive workloads. Every year, more doctors report working beyond their rostered hours and many find it increasingly difficult to take breaks. In 2022, 42% of doctors responding to a GMC survey reported feeling unable to cope with their workload, 25% were at high risk of burnout and 22% took a leave of absence due to stress. The GMC's largest study to date on attrition in 2021 found that 27.7% of those who had decided to stop or take a break from practising medicine cited burnout or work-related stress as the primary reason for doing so. For GPs, this figure reached 42.8%.

As a result of pay erosion and poor working conditions, doctors have had to make the difficult decision to take Industrial Action. They have not done so lightly, and this has had a significant impact on the operation of the NHS this year. In total, industrial action across all doctor groups has led to over 1.6 million procedures cancelled to date. The NHS' Chief Financial Officer estimated that the strikes up to October 2023 cost the NHS £1 billion directly and additionally led to a significant

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[11] https://www.gmc-uk.org/-/media/documents/somep-workplace-report-2024-full-report_pdf-107930713.pdf

[12] BMA Article: A world apart

loss of activity with an estimated value of £1 billion. Funding of £1.7bn was provided to the NHS to cover the costs of strikes. This far surpassed the cost of full pay restoration. The current government has recognised doctors' concerns and have come to the table to negotiate. At the time of writing, Consultants and SAS doctors have accepted the offers put to them for 2023/24, and resident doctors are currently voting on the offer put to them for 2023/24 and 2024/25. Whilst these offers are a step in the right direction, they still leave a long way to go to reversing the many years of pay erosion staff have experienced. These offers leave the Consultant, SAS, and Resident doctors' real-terms base pay at approximately -22.7%, -19.7%, and -20.8% respectively, of 2008/09 base pay (RPI terms, and the exact erosion varies slightly for different pay scales).

In order to reduce the risk of future Industrial Action, the BMA is calling for additional funding for the NHS to ensure that pay scales are increased above RPI inflation in 2025/26 and beyond with the aim of reaching full pay restoration. This will ensure pay is more commensurate with the skills, experience and responsibility of doctors' role in the health sector and society more generally. The Treasury should urge governments across the UK to negotiate and should commit to providing additional funding to the DHSC budget and Barnett consequentials in all nations for any agreed pay uplifts negotiated with the BMA, as well as any future deals in line with recommendations from a reformed Review Body on Doctors' and Dentists' Remuneration (DDRB).[13] Furthermore, any pay uplift afforded to the NHS must be matched in the academic sector and for public health doctors working outside the NHS, as well as in the 2024/25 GP contract so salaried GPs also receive the appropriate uplift.

6. The Long-Term Workforce Plan target to increase doctor numbers will not be achieved without additional investment in the medical education training pipeline

The BMA welcomes the Government's manifesto pledge to the commitments made in the NHS Long-Term Workforce Plan to increase medical school places in England by a third by 2028/29 and to double the number of medical school training places by 2031/32[14]. This is a commitment the BMA have long campaigned for. To be successful, it is essential that these training commitments are sufficiently funded. When the plan was released in July 2023, training commitments for the healthcare workforce up to 2028/29 were backed with £2.4bn of funding. However, the amount to be spent on medical training in particular has still not yet been set out, nor has funding beyond 2028/29 been confirmed – when the bulk of the medical school expansion is scheduled to take place.

Additionally, action urgently needs to be taken to expand the rest of the medical training pipeline. The Long-Term Workforce Plan does acknowledge the need to grow the number of foundation year placements and expand specialty training in future years commensurate with the growth in undergraduate medical training but provides no detail on how this is funded or implemented. This Government must act immediately. There are already significant bottlenecks between medical training, foundation and speciality places. Medical school expansion means this is set to get worse without action. Spending on medical school expansion without an expansion of the wider training

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[13] The BMA is separately calling for reform to the doctors' annual pay review body, the DDRB. We have set out the key requirements for reform [here](), including a restoration of its independence in line with its original purpose, autonomy and authority.

[14] BMA report: **Medical academic workforce planning for the future**

pipeline does not represent value for money, nor will it deliver the additional doctors the NHS desperately needs.

Underpinning the funding for medical school, foundation and speciality training places is a need to ensure that there is sufficient human and physical capital to deliver them and accommodate the additional numbers of students and resident doctors in university and healthcare settings, including trainer numbers and placement capacity. This will necessarily require additional investment in medical school facilities and health service buildings and premises. Currently, there is little sign of the funding or planning to deliver what is needed. Between 2010/11 and 2022/23 there was a welcome 21% rise in medical students, yet over the same period the medical teaching workforce has fallen in England – demonstrating the pressure the current teaching workforce is already under.

The Government must increase the medical teaching workforce to meet increased teaching demands, as well as time and resource for senior doctors to support teaching. A flexible return to work programme for educators is urgently needed to bolster that workforce. Furthermore, any pay uplift afforded to the NHS must be matched in the academic sector. To ensure this the government's commitment to pay parity for doctors working in the academic sector (life sciences) should be backed up by the funding necessary to maintain it without further reductions in posts. Finally, there should be funding for the creation of new research and educational programs that will stabilise and reverse the decline in academic FTE numbers with the goal of restoring the relative proportion of clinical academics to students and addressing the research requirements of the life sciences sectors.

One area in the Long Term Workforce plan that the BMA has serious patient safety concerns about is the way in which Medical Associate Professionals (MAPs) have been deployed within the NHS without a clear scope of practice. The use of medical associate professionals has led to widespread confusion about their roles. Despite an insistence that MAPs are not intended to substitute for the expertise of doctors, there have been examples within the NHS of MAPs engaging in unsafe practice. It is vital that MAPs work within a safe and appropriate scope of practice and that training of these staff does not have an impact on the quality of training of doctors and other existing staff groups. All health professionals working in the NHS should be paid properly, but it a false economy to pay staff with 2 years of training a much higher salary than newly qualified doctors who qualify with student debts of up to £100,000, have undertaken significantly more training and whose roles, remit and professional responsibility is far greater. In the long run, it will most likely be more expensive to replace skilled doctors with less qualified staff (due to a decline in quality of care and the need for more costly treatment or increased medical malpractice costs).

Plans to reduce the time it takes to complete a medical degree must also be abandoned in favour of the traditional route of at least five academic years of medical training or four years by graduate entry medicine in order to maintain high standards of medical care. Similarly, all medical apprenticeship courses or pilot schemes should end immediately with an option to convert anyone already on such a course to a traditional medical degree. This would serve the dual purpose of both to maintaining the consistency and standards of medical practice and avoiding potential discrepancies in debt accumulation and pay in newly qualified doctors. A dramatic increase in traditional medical school places to meet the projected future demand on the health service, with additional bursaries and support for students from a widening participation background, is needed without delay to ensure patients receive safe care and unnecessary additional costs are avoided further down the line.

7. Investment in NHS estates and infrastructure is needed to increase productivity, improve patient care, and retain staff

An urgent and major injection of capital investment is needed to ensure the NHS can deliver sustainable service recovery. NHS estates are in an increasingly poor state, with maintenance backlogs mounting and long-term underinvestment leaving many facilities outdated, outmoded, and even unsafe. This risks severely undermining NHS productivity, patient safety, and staff wellbeing, and presents a clear threat to the success of elective recovery plans. This can only be resolved with a serious injection of capital funding. This Government has made some steps in this direction, pledging more CT scanners in their election manifesto, but further investment is needed alongside guarantees on funding announced by the previous Government.

The maintenance backlog[15] **continues to grow year on year, and reached £11.6bn in 2022/23 in England** and this does not even include GP which also requires capital investment. Meanwhile, investment to reduce this backlog remains extremely low: in the same year, this investment covered less than 12% of the total backlog (£1.4bn).

Overdue repairs pose serious safety risks to staff and patients: around 42% of the current backlog cost estimate pertains to overdue repairs that pose a significant or high risk. This issue is reflected in the number of incidents relating to estates and facilities occurring in the NHS: in 2022/23, there were on average 34 incidents per day.[16]

The longer repairs are postponed, the more expensive they get. Substantial upfront investment into clearing the maintenance backlog is needed not only to redress acute risks to patients and staff, but also to avoid even higher costs in the future. Over the past decade, the backlog increased by £7.6bn (188%). The opportunity cost of not investing in NHS estates is enormous and will only continue to grow alongside the maintenance backlog without a significant increase in capital funding for the health service.

Underinvestment in health estates and infrastructure is harming productivity: small spaces, slow IT systems, and outdated equipment slow down care delivery. , and more than 13.5 million clinical working hours are lost every year due to poor IT. The previous Government announced planned investment of £3.4bn for NHS IT improvements, which would be a significant step toward resolving this issue, but this is only due to begin from 2025/26 and has not yet been guaranteed by this Government. Productivity improvements are a key part of keeping up with growing demand for healthcare whilst keeping costs down. As noted by the Institute for Fiscal Studies, the NHS's productivity must rise significantly to avoid spending an ever-rising share of GDP on revenue for healthcare services. The Long-Term Workforce plan includes an ambitious 1.5-2% productivity target. These targets cannot be met unless Trusts receive additional funds to invest in better buildings and infrastructure, including IT, which will allow staff to deliver care more effectively and efficiently by improving patient flow and freeing up staff time.[17]

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[15] The maintenance backlog is an estimate of how much investment is needed to restore NHS buildings against assessed risk criteria. It does not include planned maintenance work, only work that should already have taken place.

[16] This figure is a sum of all estates and facilities related incidents (12,377) divided by 365.

[17] BMA NHS Long-Term Workforce Plan Analysis

Capital underinvestment is also harming patient care. In a 2022 BMA survey, 43% of respondents reported that the physical condition of the building in which they work has a negative or significantly negative impact on patient care, and a lack of bed stock has been a long-standing issue in the NHS which often results in delayed care. For example, the latest available OECD data shows that the UK only has 2.4 hospital beds per 1,000 inhabitants, compared to an OECD average of 5 per 1,000.[18] Capital investment is needed to make sure patients receive high-quality care in a timely manner: for example, the BMA endorses the Royal College of Emergency Medicine's call to restore the admissions to beds ratio to 2017/18 levels (48%).[19] Overall capacity in social care must also be improved so that patients can be discharged from hospital on time, rather than occupying beds when medically fit to be discharged. Underinvestment in NHS infrastructure has also left the NHS with insufficient equipment, particularly critical diagnostic tools like CT and MRI scanners that are essential to timely diagnosis and treatment of cancer. OECD data shows that the UK has 10 CT scanners per 1,000 people compared to an average of nearly 20 per 1,000 across other European OECD nations, while the UK has 8.5 MRI scanners per 1,000 people compared to an average 12 per 1,000 people across EU nations.[20] Therefore, the government's promise to double the number of those scanners is both welcome and critically important.

Capital investment is needed to improve staff wellbeing and retain staff. Inadequate buildings and poor infrastructure are detrimental to staff morale, and ensuring staff have the spaces and tools available to deliver high-quality care and take adequate rest breaks should be a key part of any retention strategy. Doctors, for example, require a designated working space equipped with IT and office furniture to complete their clinical and administrative tasks, as well as an adequate rest space. With high levels of attrition and vacancies, the NHS cannot afford to lose staff over poor estates and equipment.

The New Hospitals Programme was always insufficient, but investment cannot be scrapped. The BMA is one of many organisations that cast doubt on the NHP and its scope, funding, and timelines, and so we understand the move to reassess how the programme will move forward. As the Government has already made clear, the necessary funding for the full delivery of the NHP was never made available and, as the NAO and others have stressed, the programme was making slow progress, with the first of the '40 new hospitals' – The Dyson Cancer Centre - only opening its doors in 2024.[21] [22] However, given the undeniable scale of need across the NHS, it is imperative that the funding promised to those hospitals selected is provided and that, rather than scale back investment, more expansive plans for improving NHS estates are put forward. Without the funding allocated under the NHP, the selected sites will continue to struggle, and the cost of any eventual improvements may grow even higher. Failing to invest significantly in the NHS estate now will only lead to more resources being ultimately wasted on remedial repairs and temporary solutions – such as roofs held up with scaffolding as seen at the Queen Elizabeth Hospital in King's Lynn – which divert vital resources away from genuine, future-proof improvements that can deliver genuine efficiencies and better care.

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[18] BMA Hospital Beds Data Analysis

[19] In May 2022, returning to these levels required an 10,300 extra NHS beds in England. Note that this target can be achieved through an increase of bed stock, but also through innovations such as bed management systems and other improvements resulting in better patient flow (or a combination of all).

[20] BMA Diagnostics Data Analysis

[21] National Audit Office: Progress with the New Hospital Programme

[22] Dyson Cancer Centre officially opens in Bath - BBC News

8. Improve mental health and population health and reduce pressure on the NHS by focussing on health in all policies and increasing the public health grant

Good mental health is essential to a functioning society. Untreated mental health problems carry a huge cost to individuals, society, and the health and social care system. Without treatment or support, mental health problems can lead to lost productivity and the need for informal care (whereby a member of the household cannot work because they are looking after another member of the household with poor mental health). Mental ill health has been estimated to cost around £118 billion annually to the UK economy, or nearly £101 billion in England alone, equivalent to roughly 5% of the UK's GDP.[23] Mental health problems and poor mental health can also influence all aspects of a person's life and relationships, often causing huge anguish to individuals, families, and communities.

Demand for mental health services has increased significantly over the last few years, yet resources provided have not kept pace with demand. Modest funding increases have done little to meet demand for mental healthcare which has skyrocketed. Between June 2016 (the first year that comparative data is available) and June 2024, the number of new referrals to NHS mental health services in England grew by 61% - much higher than the real terms funding increase and the growth in workforce. And these figures only capture those in contact with services – it is estimated that millions more would benefit from support but have not accessed services.[24] Further, rising thresholds for accessing care due to scant resources at a time of heightening demand has led to people falling through the gaps, and receiving inappropriate or no care at all.[25] We welcome the current Government's commitment to expanding the mental health workforce by 8,500 staff, but it is essential that this is made up of highly qualified staff, including doctors, nurses, and psychological therapy practitioners. The target should be reached by prioritising the training and employment of staff with the requisite qualifications for well running NHS mental health services.

The key issue is that funding allocations provided for mental health have not been based on demand or need for services. DHSC should determine funding targets based on a full assessment of unmet need (such as people unable to access the right care or those on waiting lists), rather than simply just increasing funding compared to historical rates. Services to meet both current and unmet need should then be fully funded by the Treasury. The data and assumptions used to determine need should be published so it is clear and transparent how funding was determined. There also needs to be more regular and timely data collection of prevalence of mental ill health to ascertain the level of need and inform how much funding is needed. The current survey of adult psychiatric morbidity should happen with greater frequency (for example, it should be conducted every four years rather than every seven).

Public health should also be an important focus for investment. A comparison of public health interventions and clinical interventions found that a public health intervention costs only a quarter of a clinical intervention to add an extra year to life expectancy.[26] In addition, a failure to properly resource public health has costly implications for the NHS - the BMA has highlighted how doctors and the health service are picking up the pieces from the failure to properly resource public health. It is vital that national public health bodies are sustainably funded for routine public health functions but also adequate provisions for rapid responses to large scale public health emergencies, learning from the COVID pandemic. It is well evidenced that public health interventions both nationally and locally offer substantial returns on investment.[27]

The BMA is calling for the local authority public health grant in England to be restored to at least 2015/16 levels per capita in real terms to allow sufficient investment in public health, with comparable additional funding provided for all other nations. Since 2015/16, the public health grant has been cut significantly by 28% in real terms. Some of the largest reductions in spend over this period are estimated to have been for sexual health services (40%), public health advice (35%) and drug and alcohol services for young people (31%). It is vital the public health grant is restored in order that these vital preventative services can be provided adequately by local authorities.

The NHS is increasingly having to bear the brunt of increases in alcohol harm because of increased alcohol use and cuts to preventative services. Alcohol harm costs NHS England at least £4.2 billion every year. These estimates (although readjusted in December 2023 to reflect inflation) have not been revised since 2012, and are expected to be significantly higher, particularly factoring in increases in alcohol harm and drinking levels during the pandemic. Alongside the Alcohol Health Alliance (of which the BMA is a member), the BMA is calling for the introduction of an automatic uprating mechanism to increase alcohol duty by 2% above inflation at the Autumn Statement. This would maintain the positive impact of changes to the duty system in August 2023 and ensure that momentum isn't lost by inflationary changes. England should also be brought in line with Scotland and Wales by introducing minimum unit pricing. These measures, alongside proper funding of public health services, would raise revenue, save lives, decrease harm from alcohol and ease the pressure alcohol puts on public services.

Cuts to smoking cessation services are also putting additional pressure on the NHS. Smoking causes myriad health harms, including 16 types of cancer, heart disease, chronic obstructive pulmonary disease, strokes and it also increases the risk of dementia. This puts a huge strain on our already overstretched NHS. In England alone, smoking is estimated to cost the NHS £2.4bn every year. Yet smoking cessation services have been cut significantly, with funding falling by 45% in real terms between 2015/16 and 2023/24. The BMA welcomes the announcement of an upcoming Bill aimed at tackling youth smoking and vaping, but it is also crucial that long term funding is committed to stop smoking services across the UK to help people quit.

The Treasury should also introduce a new commitment in the upcoming Spending Review to make improving health and wellbeing an explicit objective in every major policy decision. The social determinants – the conditions in which we are born, grow, live and work – have a huge impact on health, and therefore nearly all policies have an impact on health. All policies should therefore be explicitly assessed in terms of their impact on health. The BMA strongly welcomes the UK Government's commitment to a health mission delivery board to ensure that all departments with an influence over social determinants of health work together. The health mission delivery board must be funded appropriately to realise the UK Government's welcome ambitions to halve the gap in healthy life expectancy between the richest and poorest regions in England, and to cut waiting times in the NHS.

The Treasury should expand the Sugar Drinks Industry Levy (SDIL) to other sugary products, and other food and drinks High in Fat, Salt, and Sugar (HFSS) content. Mandatory levies are far more effective than voluntary measures. The Sugar Drinks Industry Levy has been successful in reducing sugar in our drinks, where the voluntary targets on industry to reduce sugar have not been. The SDIL has removed significant levels of sugar in our drinks and has shown considerable promise in its impact on health inequalities. One study found the largest absolute reductions in purchased sugar in the 2 most deprived quintiles since its introduction.[28] Expanding the levy to other products that would benefit from reformulation should be considered an important policy, along with funding obesity and overweight treatment services. These must be funded in a sustainable way, that seeks to fund long-term provision as opposed to the current short-termism in the system. Funding treatment services and introducing measures to reformulate foods through mandatory levies are important measures for the Treasury to take should the UK Government wish to achieve its ambitions to improve children's health, halve the gap in healthy life expectancy, and reduce demand on the NHS.

Poverty and economic insecurity are destroying people's lives, destroying people's health, and placing avoidable demands on the NHS. Doctors are extremely concerned about what they are seeing in their day-to-day work. Patients are coming to them in very difficult circumstances that cannot be solved by medical care alone. Poor housing, lack of good-quality employment, and money worries are all social determinants of poor health. While doctors can treat the symptoms, they are often powerless to address the underlying causes of the mental and physical ill health that patients experience. The Government must respond to the huge demand for a stronger financial security net. A failure to do so will likely incur avoidable costs for both the health service and those struggling to make ends meet. More needs to be done to stop people from falling into poverty. Over the long term, the Government should explore reforms to ensure that both social security and wages guarantee everyone can access the income they need to stay healthy and well.

Occupational health is a crucial part of getting people back to work and growing the economy. Occupational health physicians are trained to undertake health assessments and to provide rehabilitation to staff returning to work following illness or injury. They will also advise employers about suitable alternative positions for staff temporarily or permanently unable to perform their existing role. They are therefore indispensable to getting people back to work and growing the economy. However, occupational health support is extremely inconsistent across the UK, largely due to falling staff numbers. Where there were 172 occupational physicians working in the NHS in England in 2009, there are now only 88. Poor provision is likewise the case for healthcare workers.

The BMA was interested in the announcement in the last Budget under the last Government about an occupational health service for all under the WorkWell Initiative. We are sceptical that this programme will even begin to meet the needs of workers in the UK given current occupational medicine staff shortages, however it is a step forward for a truly universal, free at the point of access, occupational medicine system. We hope to work with stakeholders and the current Government to improve the system. We are calling on the Treasury to fully fund this scheme with an added goal to increase funding in the future, for a universal occupational health system for workers.

[28] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11008889/