BMA

Funding Priorities for the Health and Care Sector: The BMA's submission to Phase 2 of the Comprehensive Spending Review, Spring 2025

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Introduction

About the BMA. The British Medical Association (BMA) is the 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 view on what the funding priorities for Government should be over the next three financial years and beyond. As set out in this submission, the BMA believes that significant sustained investment into the Department of Health and Social Care is needed to increase NHS funding (section 1), particularly GP funding (section 2), to fund staff pay increases and restore relative pay losses (section 4), expand the medical training pipeline (section 5) and to improve infrastructure (section 6). In addition, further attention must be paid to financial disincentives penalising doctors for taking on additional hours – pensions and childcare (section 3). Finally, there must also be significant additional investment into public health, mental health and social care (section 7).

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.

The healthcare system is facing considerable challenges as highlighted by Lord Darzi's recent review, but we share the new Government's ambitions to get the NHS back on its feet. Announcements in the recent budget to increase healthcare spending and capital investment were welcome, but after fifteen years of underinvestment and lack of a long-term strategy, this will not be enough to deliver much needed improvements. The cumulative underspend on the health in England between 2009/10 and 2022/23 was £446 billion, had spending growth kept pace with pre-2009 trends. With waiting lists for physical and mental health reaching unprecedented highs, health facilities left in disrepair, and patients struggling to even see their GP, the ability of the healthcare system to meet demand will continue to be hampered. This means ongoing increases in investment are needed.

Staff are the NHS. However, doctors have seen their pay and conditions deteriorate significantly under the previous Government and been left to deal with results of years of underinvestment, the legacy of the pandemic and intensifying demand pressures. Doctor's pay fell by 20.9% - 23.8% between 2008/09 and 2024/25 in real terms (RPI terms, the erosion varies by branch of practice and pay point). Survey evidence collected by the BMA from before the Covid-19 pandemic found that burnout was pervasive among doctors, with many reporting both physical and mental exhaustion and general disengagement with their work. The pandemic and rising demand have exacerbated the pressures that contribute to burnout. The General Medical Council's (GMC) latest workforce survey found that 33% of doctors were struggling with workload, and regularly worked beyond their rostered hours, not feeling able to cope. The GMC's largest study into attrition, conducted in 2021, found that 28% 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.

The government has rightly pledged to deliver economic growth and fix the foundations of the UK economy, but inadequate healthcare is costing us all dearly. Over 300,000 working-aged people have left the workforce with a work-limiting condition. Many patients are going without the treatment they need. Estimates by the Institute for Public Policy Research (IPPR) suggest that reforms aimed at bringing down waiting lists could generate benefits worth £73 billion for the UK

economy over 5 years. To reverse the managed decline of our economy and critical public services, we need to boldly invest in our NHS, its staff and the health of the population.

The BMA has put forward a package of funding proposals that would take significant steps towards restoring the NHS and wider health system to one that meets the needs and expectations of the public. We understand the fiscal constraints and that the economic inheritance of this Government has put it in a challenging position. However, the years of austerity have decisively demonstrated that reckless cuts to healthcare are a false economy which fail to generate savings and instead store up the horrendous costs which we are dealing with today. A healthy economy needs a healthy population; this is a chance to correct the mistakes of the past.

Summary of asks

Ensure the NHS is properly funded

- Years of underfunding the NHS need to be addressed now. Funding is needed to tackle care backlogs and make the NHS fit for the future, backed by a better deal for all staff and a stronger, more sustainable general practice. Specifically, the BMA is calling for:
    - A real-terms increase of 4.2% per year for the DHSC Resource DEL budget[1]
    - An additional £3.3 billion in real terms for each year of the Spending Review invested into the DHSC Capital DEL budget[2]

Investing in general practice

- General practice is the frontline of healthcare delivery. The Government has declared their aspiration to enhance community care and significantly improve health outcomes. Achieving this ambition requires delivering much needed and long overdue investment for GP practices so they can play a proactive role in addressing the needs of their patients and improving health outcomes across the population, as well as greater flexibility for practices with regards to existing funding, so they can recruit the GPs patients want to see and thus tackle GP unemployment. The BMA (as set out in its manifesto for GPs 'Patients First') is calling for the government to:
    - Increase the GP Practice core funding (Global Sum payment per year per weighted patient) by at least an additional £40 per weighted patient – increasing the 2024/25 payment from £112.50 to £152.50
    - Establish a minimum investment standard for general practice to determine fair annual funding increases to the GP core contract for essential patient services and commit to a capital programme to secure GP estates and premises

Tackling financial disincentives

- With mounting care backlogs, it is vital that steps are taken to reduce barriers within the tax and benefit system that prevent doctors from taking on additional hours. The BMA is calling on the government to:
    - Index the annual allowance threshold to inflation and provide a solution for the unfair interaction of the annual allowance taper and NHS defined benefit scheme to protect doctors from punitive taxation measures for working longer hours

[1] This includes a general rise in resourcing of 3.3%, as recommended by The Health Foundation as the amount necessary to achieve sustained improvements in NHS services, plus additional funding for increasing the GP Global Sum Payment and achieving pay restoration for secondary care doctors

[2] The Total DEL budget for DHSC should rise on average by a minimum of 4.34% during the period of The Spending Review

- Publicly commit to retain the abolition of the lifetime allowance and to not introduce a flat rate of tax relief on pension contributions or reduce the tax-free pension lump sum
- Remove the eligibility threshold to access 30-hours of free childcare or tax-free childcare
- Restore the High-Income Child Benefit Charge threshold from £60,000 to £68,461, rising to £69,625 in April 2025, in line with inflation since 2014 (when it was introduced)

Improving pay and conditions

- The erosion of pay and conditions has driven many doctors to leave the NHS early. This is exacerbating the workforce crisis and undermining the health and wellbeing of both NHS staff and patients. The BMA is calling for:
  - Full pay restoration for secondary care doctors who have experienced real terms pay cuts, at a net cost of £2.7 billion
  - Ensuring pay restoration for GPs, including salaried GPs, through uplifting the Global Sum payment and
  - Pay restoration through improved local authority funding for public health doctors working outside the NHS

Medical education and training

- The existing Long-Term Workforce Plan requires the training and development of new doctors and has committed to doubling the number of medical school and foundation programme training places by 2031/32.
- The BMA supports this, but is calling for:
  - Investment in increasing postgraduate training places along the medical training pipeline, from medical school all the way to speciality training. The current self-imposed bottlenecks need to be resolved urgently to avoid losing resident doctors or delaying their training while patients cannot see their doctor.
  - Sufficient investment to achieve an increase the number of medical student places from 7,500 to 10,000 by 2028, in line with the government's target of doubling the number of places by 2031
  - Ensure that medical students have access to the full maintenance loan during their years of NHS Bursary funded study to prevent a significant fall in their incomes, while ensuring the value of the NHS bursary is uprated in line with inflation
  - Ensure academic medicine remains attractive to support this expansion, the BMA is calling for parity of pay between doctors working in the academic sector and the NHS, with appropriate ring-fenced funding made available

Investment in public health and mental health services

- Public health is critical for alleviating pressures on the NHS, improving health outcomes and reducing health inequalities. Efforts to improve both mental and physical population health requires targeted investment to improve existing services. The BMA is calling for:
  - Restore the Public Health Grant in real terms to 2015/16 levels, via a phased in approach to reach £1.4 billion extra per year, amounting to an additional £4.6 billion in investment over the next 5 years

- Establish a strategy to enhance public health investment over the long-term to ensure that enough is being dedicated to tackling health inequalities and delivering stable improvements to health outcomes across the population
- An increase in budget for both the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID), including the proportion going towards enhancing health protection
- Adequate investment for mental health services, social care, and tackling the wider social determinants of poor health to alleviate pressures on the NHS and ensure people are supported in maintaining good physical and mental health

1. The additional NHS investment in the budget was welcome, but it must be sustained and built upon to yield long-term benefits

The BMA welcomed the additional funding for the NHS in the Autumn Budget, but this represents only one step towards helping the NHS on the road to recovery. 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 or able to tolerate. Fixing it requires sustained investment, but that is investment that will reap future dividends for the UK population and the UK economy, increasing productivity and driving growth in line with the government's missions.

Real terms spending growth in the health and care system since 2009/10 has been significantly below historical averages. Between 1955/56 and 2009/10, health funding increased at an average rate of 4.3% per year. This fell to just 1.1% during the coalition government (2009/10 to 2014/15) and even through the last Parliament (2019/20 to 2023/24) which had to deal with the Covid-19 pandemic, health spending only increased by 3.5%. The BMA has estimated that there has been a cumulative underinvestment of £446 billion into health since 2009/10 compared to if spending had increased at the same pace as the historic average during this period.

The BMA recognises the recent efforts of this government to boost healthcare spending. The Autumn 2024 Budget promised a funding increase of 3.8% per year on average in real terms between 2024/25 and 2025/26. However, this is still significantly below the average funding increases of 6.7% delivered by the previous Labour government.

While healthcare funding has stagnated, demand pressures have intensified. The health system in the UK, like in many other countries, is under consistent and growing pressure from the impacts of population growth, an ageing population with increasingly complex healthcare needs, and rising relative costs of treatments including drug prices – which is why it is vital that provision keeps up with need.

Past real-terms funding cuts have left NHS services under extreme financial pressure. Trusts are facing large financial deficits, with the National Audit Office (NAO) estimating an aggregate deficit of £1.4 billion among the 42 Integrated Care Systems (ICS) subject to audit in 2023/24. Many NHS Trusts, Integrated Care Boards (ICBs) and primary care providers in England are required to make financial savings. Survey evidence from the NHS Confederation found that 67% of respondents from NHS Trusts and ICBs planned on reducing clinical staff to meet cost saving targets. This is something patients cannot afford. The most recent BMA snapshot survey of GP practices found that 57% had experienced cashflow issues in the previous 12 months, while 64% reported concerns over their viability to remain open.

Such cuts diminish healthcare capacity and adversely impact patient care. 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 a third of respondents were confident that their system would 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.

The situation is not any better in general practice, which – as many of our members are telling us – has become financially unviable. There are 1,167 fewer qualified full-time GPs today than in September 2015, which alongside rising patient demand means that each GP is now responsible for around 17% more patients than in 2015. However, underfunding has also resulted in systemic issues that have prompted the loss of 200 independent GP practices in England since April 2022. The recent measures taken by DHSC to allow practices to use funding from the Additional Roles Reimbursement Scheme (ARRS) have been a welcome first step in addressing the issue of GP unemployment. However, the fact remains that at a time where demand and pressures on the GP workforce are rising, medical unemployment and underemployment remain common.

Spending cuts manifest in a reduced workforce, struggling to meet the needs of patients. This is made worse by significant vacancies. There were over 107,000 staff vacancies across the NHS as of September 2024 but due to the financial pressures, many secondary care trusts have imposed recruitment freezes and even voluntary redundancy programmes. The latest data suggest that there are 7,768 medical vacancies in secondary care. The UK already has comparatively lower doctor numbers than many EU members of the OECD. For members with available data there are an average of 3.9 doctors per 1,000 people. To reach this rate, the UK would require almost 49,000 additional doctors across the country.

Primary care has been severely damaged by persistent under-investment, with many patients struggling to access what was once the family doctor. The average GP practice now receives just 31 pence per patient per day, for the unlimited work that is required to meet their health needs. Around 2,000 independent GP practices have been lost since 2010, one in five local surgeries. This undermines patient and community care, prompting patients to turn to overcrowded emergency departments, and puts immense strain on GP surgeries required to do more with less. As noted in Patients First, a vision document by the GP Committee England (GPCE), we need a fair funding settlement for family doctors to ensure their practices remain open and they recruit the staff they need. That will allow them to deliver more care, and re-ignite patients' hope in the ability of the NHS to meet their needs.

Doctors and patients in secondary care find themselves within an under-resourced and over-stretched system, that also struggles to meet their needs. The NHS has one third of the number of hospital beds compared to Germany, for example. Overcrowding results from there being an insufficient number of beds within the system for patients who require admission, as well as the inability to discharge patients into the community due to pressures in social care (see also section 7). Additional bed capacity is needed to allow the NHS to respond to the changing flow of demand. However, in last three months of both 2022/23 and 2023/24, bed occupancy rates exceeded 92%, the absolute limit set by the NHS operational planning guidance in 2023/24. Such high bed occupancy levels are not just clinically unsafe but are also associated with longer stays and worse clinical outcomes, leading to greater costs.

Emergency departments are under unprecedented severe pressure and suffering from excessive crowding. Crowding also has a direct impact on patient mortality and poor patient outcomes.[3] It

[3] 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.

creates inefficiency in the delivery of care as well as increasing the rates of stress and burnout amongst staff. It is essential that there is additional investment in both primary and secondary care, beyond that required to cut waiting lists, to ensure that critical patient services can be delivered sustainably. Without building that additional capacity, the NHS will be unable to identify patient needs, or deliver the safe, dignified, high-quality care they deserve. The same investment in additional capacity to address waiting lists could logically be planned for cross-utilisation as surge capacity when the NHS is exposed to sudden shocks, such as pandemics, the lack of which threatens to undermine its response in emergencies, as the public inquiry into the Covid-19 pandemic so sadly confirmed in its module 1 report recently.

A persistent lack of capital investment has further contributed to a productivity crisis engulfing the NHS. In his recent review of the NHS, Lord Darzi found that the NHS had been "starved of capital" with capital budgets often being used to cover holes in day-to-day spending. Crumbling estates and outdated medical and digital technologies are endangering the safety and wellbeing of both staff and patients. The symptoms of this underinvestment are plain to see; dilapidated GP surgeries, significantly higher waiting lists, and unacceptable corridor care are but some examples. Spending cuts implemented to prompt efficiency measures have proven a false economy, fundamentally eroding the capacity to deliver quality care and causing costs to surge as the NHS can no longer keep up with demand and repair bills mount.

As this government clearly recognises, public sector capital investment (e.g. 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 economic 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 capital funding in previous financial years have been counter-productive. Funding pressures have meant that funding earmarked for capital improvements, vital to long-term productivity growth and future financial stability, has had to be reallocated from capital budgets to top up day to day spending. We welcome the Chancellor's announcement that capital budgets will no longer be subject to this erosion, but alongside this it is crucial that the NHS receives real-terms, year-on-year revenue budget growth.

Departmental funding asks

Therefore, the BMA is calling for the DHSC budget to be increased to appropriately resource the day-to-day running of the NHS and deliver much needed capital investment into health infrastructure.

The Resource Departmental Expenditure Limit (RDEL) for DHSC should be increased at a minimum of 4.2% per year in real terms over the next 4 years. The Institute for Fiscal Studies has estimated that an increase of 3.6% is required just to meet the costs of the NHS workforce plan. However, the Labour Government has declared an ambitious vision for the health service, and further resourcing is required. The amount we recommend would help deliver sustained improvements for both primary and secondary care services (for further detail on the BMA's primary care asks see the next section).

In addition to increases in the RDEL budget, the BMA is also calling for a separate funding boost to the Capital Departmental Expenditure Limit (CDEL). Capital investment is critical for enhancing productivity in the NHS, and the BMA is re-iterating its call for £6.4 billion to be delivered in real-terms over the course of the spending review period, in line with the recommendations of the NHS

Confederation. However, thanks to the commitments in the most recent budget which have already increased capital investment by £3.1 billion, this will only require an additional £3.3 billion in funding.

The combination of both these increases would amount to an average annual increase in health budgets of 4.3% - in line with the historic average prior to the years of austerity which so badly damaged the entire health system. It is important to stress that this is the bare minimum expectation. With increasing pressures on the NHS, the legacy of the pandemic still impacting services, and growing competitiveness of international healthcare systems for doctors seeking a better work life balance, it is vital that investment into health is responsive to future needs.

2. There must be increased investment in general practice, benefitting the entire health system

General practice is a vital part of the healthcare system, providing excellent productivity and value for money. Research has suggested 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. If GPs fail the NHS fails.

Investment into the core GP contact has not kept up with increasing cost pressures faced by practices in recent years. For delivering core GP contract services, a practice receives a set payment per weighted[4] patient. This is called the Global Sum, and high inflation between 2021/22 and 2023/24 caused its real-terms value to drop. The DDRB-recommended uplift in 2024/25 partially reversed this erosion, but not fully. This needs to change.

Whilst the value of patient funding has eroded, demand continues to increase. Every year, practices are expected to deliver more and more care per patient: between 2000 and 2019, the average number of practice visits per patient more than doubled, from an annual average of 11 to 25.[5]

The increase in demand is driving up cost pressures further. Having to deliver more and more appointments means practices running costs rise continuously, making them ever more financially unviable. In 2008/09, 60% of GP contractor earnings went to expenses. In 2022/23, this had risen to 72%. Further inflationary pressures in subsequent years have likely pushed this proportion further upward. As such, Global Sum payments need to see real-terms growth every year, and stagnation in recent years is driving practices and GPs into the ground.

Increased demand without increased funding means practices can't sustain or build the capacity required to deliver safe patient care. Practices unable to cover rising expenses are being forced, amongst other things, to reduce their staff numbers.[6] Some practices are unable to afford much-needed locums, fuelling locum unemployment. Some practices have also been unable to offer staff pay rises in line with inflation or that fulfil government commitments, resulting in reduced staff morale and retention issues which ultimately impact services provided to patients. Partners themselves also remain exposed to unlimited liability, made worse by years of underfunding.

All of this leads to an unsafe workload for GPs and other staff. A single full-time GP is now responsible for 2,260 (who are visiting their practice more often), which is 322 (17%) more than in

[4] The amount of money a GP practice receives is not just based on how many patients they have on their list, it also depends on the demographic characteristics of those patients. Patient lists are 'weighted' to adjust for factors that are associated with a higher workload – including age, gender, chronic illness/additional needs, list turnover, staff market forces factors, i.e. the geographical variation in staff costs, and rurality.

[5] Kontopantelis et al. (2021). For consultations with GPs specifically, the annual average increased from 5 to 8 per person. This is due to factors such as an ageing population and a rising prevalence of complex conditions and multimorbidity.

[6] The BMA's Practice Finance Survey 2024 found that, in 2024/25, three in four (76%) responding practices reduced their GP locum usage, and a further 12% were considering doing so, and a quarter (27%) of responding practices were hiring fewer salaried GPs than required, with a further quarter (25%) considering doing so in the same financial year.

2015. This has become unsafe for patients as well as staff and the additional pressure this creates forces more GPs to reduce their hours or quit the profession altogether.[7] This further depletes the available GP workforce and impacts patient care, resulting in a vicious cycle of unsustainable pressures.

Patients too often struggle to get a timely appointment,[8] and some practices have even been forced to close or merge: between 2013 and 2023, the number of general practices fell by 20%.

The long-term sustainability of the NHS requires patients to have access to their family doctor, and able to provide unique continuity of care 'from cradle to grave'. The Government has spoken in detail about their desire to enhance community care. GPs are foundational to this aspiration, advocating for patients, supporting prevention, managing risk and uncertainty, and delivering a holistic person-centred approach to care, to ensure patients receive the interventions they need. To achieve this general practice must be properly resourced.

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 the commitment to 'bring back the family doctor' and provide greater resources into primary medical services in line with the Government's election manifesto.

The BMA wants to see GP practice core funding (Global Sum) to increase by at least £40 per weighted registered patient in England to address these issues now, requiring an investment of at least £2.5bn overall. This funding for general practice is included in the BMA's overall revenue funding ask for DHSC over the next three years. This uplift would allow GP practices to take a first significant step towards pay restoration for all general practice staff, hire the additional staff required for patient care, and address urgent cost pressures which may otherwise lead to closure.

In addition, there must be a commitment to properly resource general practice for the longer term. This Spending Review must allocate sufficient long-term recurrent funding to primary medical services to deliver on the Government's commitment to bring back the family doctor a**nd to ensure patients can access care locally, a key priority of the forthcoming NHS 10-year plan.**

Patients deserve a new GP contract for England. The contract must be fit for purpose, 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 value for money continuity of care for years to come.

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

[7] 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.

[8] The latest GP Patient Survey (2024) suggests 34% of patients felt they had to wait too long to obtain an appointment with their practice.

and practices that have the opportunity to deliver efficient, high quality, safe preventative and long-term expert generalist-led continuity of care.

Only a significant increase in NHS resource 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.

However, beyond additional funding, greater flexibility around existing funds should also be introduced. For example, the Additional Roles Reimbursement Scheme introduced in 2019, should be repurposed to allow practices to employ more of the GP and practice nurse roles they need at practice level and reduce GP un- and under-employment. The Government should also implement strategies that will help grow the long-term GP workforce and ensure that GPs can find the NHS work that they want. This will require new, targeted recruitment schemes to encourage doctors to train in understaffed areas, the creation of fellowship schemes to support newly qualified doctors, including those from abroad, move to under-resourced areas (e.g. covering of relocation expenses).

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 get there by taking collective action which remains ongoing. 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.

3. Significant financial disincentives to work – pensions and free childcare – must be fixed

With mounting backlogs of care, it is crucial that, alongside continuing to improve pay (see section 4), the Treasury takes clear and active steps to reduce barriers within the tax and benefits system that prevent doctors taking on additional hours. No doctor should be discouraged from working the maximum number of hours they want to because of poorly designed financial incentives. 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 combined impact of the personal allowance and childcare tapers.

Pensions

The main priorities regarding pension taxation are indexing the Annual Allowance threshold and providing a solution for the unfair interaction between the Annual Allowance taper and the NHS Defined Benefit pension scheme.

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 pension 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.

In addition, many GPs will need to reduce their working pattern to avoid being caught by the financial penalties that result from the tapered Annual Allowance and have the added challenge that, particularly in England, their pension records have not been updated due to maladministration by Primary Care Support Services England (PCSE).

The BMA would also like to reiterate that it is essential that the Lifetime Allowance is not reintroduced and that there are no further detrimental changes to pension taxation implemented. As previously expressed ahead of the Autumn budget, we remain concerned about ideas such as flat rate pension tax relief and taxes on pension lump sums. These would disincentivise doctors to work and jeopardise the Government's elective recovery plans. Any detrimental changes to the treatment of tax-free lump sums is also likely to trigger an increase in early retirements which must be avoided given the precarious state of the NHS as outlined by Lord Darzi in his report. The BMA is due to meet with Treasury in March to discuss these issues further.

Annual Allowance

The design of the Annual Allowance (AA) 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 to avoid financial penalisation. Although the removal and abolition of the lifetime allowance (LTA) and the increase in the AA announced in the Spring Budget 2023 by the previous Government partially removed the perverse incentive pushing doctors to retire early, they

didn't fully resolve the problem with pension taxation, as the design of the AA and in particular the tapered AA have not been meaningfully reformed.

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 value of the AA threshold currently continues to erode and must be indexed to inflation going forwards. The AA increase from £40,000 to £60,000 took effect from April 2023 and it remains unchanged. For example, had the AA been increased in line with previous September CPI inflation since 2023/24, the inflation statistic used to increase NHS and other public sector pension benefits, the AA would have grown to £64,020 in April 2024 and would be set to rise to £65,108 in April 2025. 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.

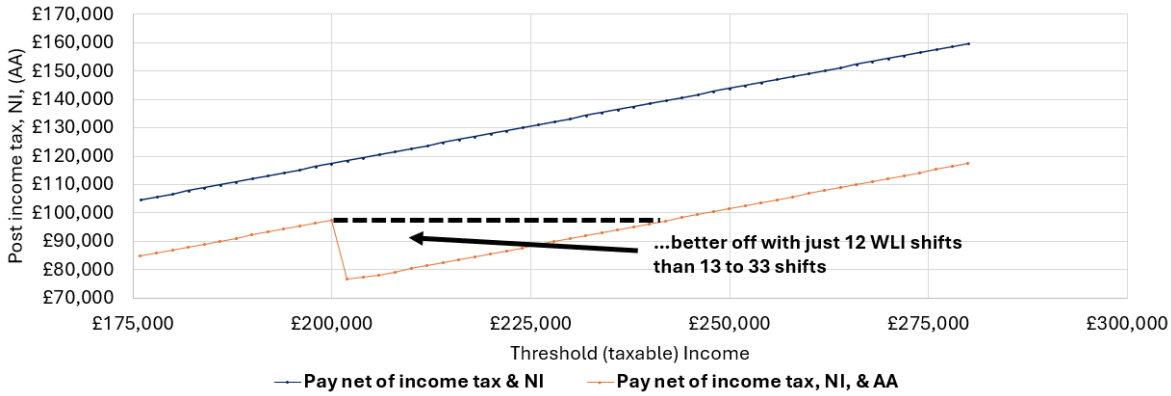
Annual Allowance taper

The changes made by the previous Government did not address the impact of the tapered AA. The tapered AA 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. Had the threshold income been increased in line with previous September CPI inflation since 2020/21, the value would have grown to £243,448 in April 2024 and would be set to rise to £247,587 in April 2025. 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. To avoid these financial penalties, doctors are left with little option but to reduce their hours or decline to take on additional work 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 them effectively "paying to work" even if they undertook up to 21 waiting list initiative (WLI) weekend shifts of 10 hours each remunerated at £2,000 per shift. Indeed, it's notable that the DHSC also recognised the detrimental impact of this cliff edge on the NHS in their DDRB evidence.

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 AA is its impact on those who may choose to retire and return, rejoining the 2015 Scheme. 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 £200,000. This may provide a further serious disincentive to do additional work due to the highly punitive nature of the tapered AA- 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 AA was introduced.

The spectre of the tapered AA continues to present a significant barrier to NHS capacity, especially following recent, albeit crucial in the face 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 AA 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 AA 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%.

T**he BMA believe that to maximise NHS capacity, the tapered AA should be scrapped to remove this tax cliff.** This is a poorly designed tax cliff that limits the amount of work that doctors can do, thereby limiting access to care for patients. In addition, it potentially reduces overall tax revenues as people limit earnings to stay below the threshold and increases the need for locum and agency spend to cover service gaps.

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 AA 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.

The BMA has previously said that our preferred solution would have been to remove the AAfrom 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. Indeed, the interaction between the pension taxation rules and defined benefit schemes such as the NHS are so complex that even the scheme administrators are struggling to calculate pension growth correctly. In England and Wales, NHSBSA missed the statutory deadline of the 6th October 2024 for sending out pensions savings statements (PSS) to its members that had exceeded the annual allowance and only last week was forced to apologise and refer itself to the Pensions Regulator as the PSSs it did send out contained significant errors. This has left tens of thousands of doctors unable to accurately complete their tax returns before the HMRC deadline.

However, any proposals set out above, that would protect doctors from punitive taxation measures for working longer hours for the NHS would be welcomed by the BMA and our members.

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.

Lifetime Allowance, flat rate pension tax relief, and changes to pension lump sums

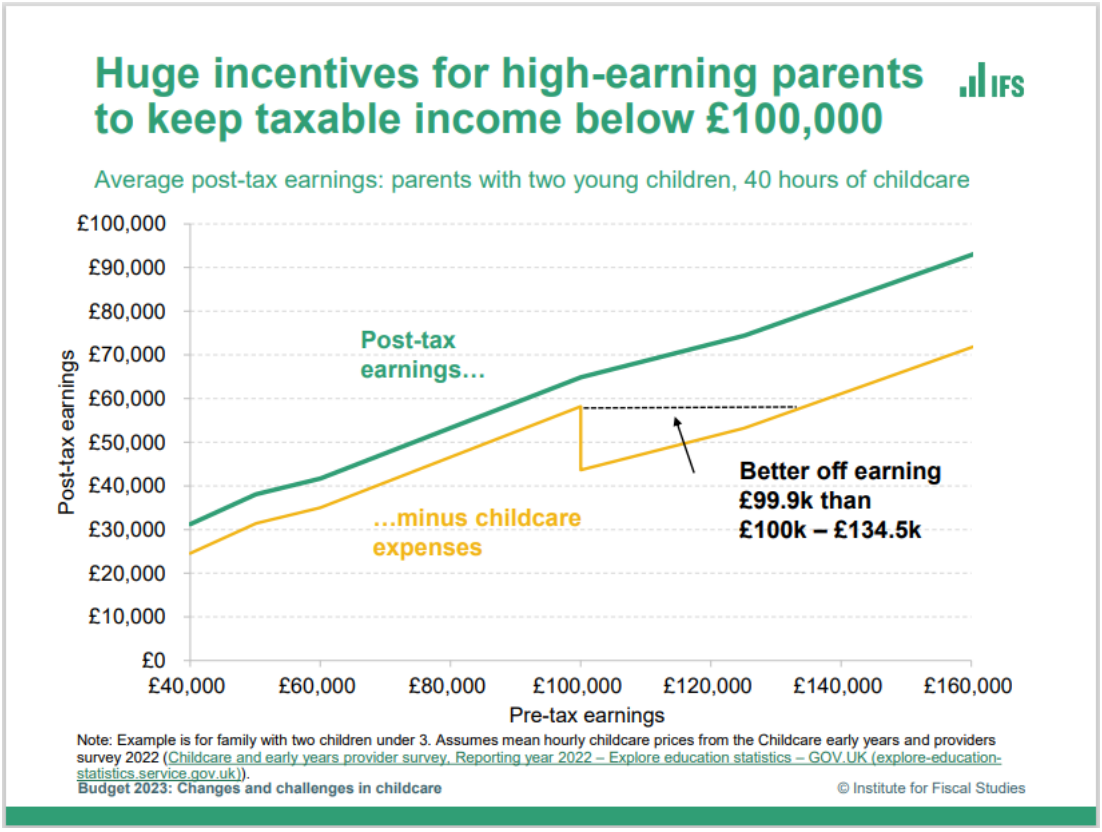
The BMA wants to reiterate that is essential that the Lifetime Allowance abolition is retained and that new detrimental changes to pension taxation are not introduced. We were pleased that the Labour Party did not include plans to reintroduce the LTA in their manifesto or in the Autumn 2024 budget. Such a move, especially without guarantees about how public sector workers would be protected, would cause many 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.

As expressed ahead of the Autumn 2024 budget, we are concerned about any proposals 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. We were therefore pleased that there were no such detrimental changes to pension taxation relief in the Autumn 2024 budget. **We ask that, beyond remaining silent, the Government publicly commits to retain the Lifetime Allowance abolition and not to introduce flat rate tax relief on pension contributions or to reduce tax-free pension lump sum allowances.** This will give our members certainty in their long-term retirement planning.

Childcare

Consultants, resident doctors, SAS doctors and GPs with childcare responsibilities can 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. This is of particular importance for doctors given the unsociable, long working hours they frequently undertake that require at times urgent, short term and extremely expensive childcare in order to facilitate their being able to work these hours.

Unfortunately, the eligibility threshold meaning that any individual earning over £100,000 does not qualify, creates a cliff edge for high income parents making them face extremely high effective marginal tax rates for earning over that amount, partly also driven by the income tax personal allowance taper beginning to apply at the same threshold. This cliff edge has gotten worse over time, as it has not been adjusted by inflation since its introduction back in 2017. Doctors can even be left financially worse off if the cost of the lost childcare exceeds the increase in their take-home pay. The total pay contributing to the threshold may be made up by significant out-of-hours payments and workloads on some rosters being in excess of a 48-hour week, with night-time childcare more expensive and often particularly difficult to arrange. Given the lack of support for doctors who are pregnant and breastfeeding already in the NHS, as identified by our report (enclosed here), the possibility that they would be worse off as a result of progressing in their work, on top of these issues, would further de-incentivise those who would wish to become parents from remaining working in the NHS. Fixing this is an increasing necessity therefore, in the context of increasing staff shortages, and an increasingly female workforce. We note analysis by the IFS from 2023 that illustrates this principle for taxpayers generally, reproduced here with permission.



The BMA is calling for the eligibility threshold for tax-free childcare to be removed. We were disappointed that the Chancellor did not do this in the Autumn 2024 budget. Instead, she chose to invest in more welfare counter-fraud staff in HMRC to tackle fraud and error in child benefit and tax-free childcare from April 2025.

We have evidence that doctors are reducing their hours because of this threshold. In 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, rising to £69,625 in April 2025, and it should then be indexed to inflation going forwards. We were disappointed that in the Autumn 2024 budget, the Chancellor did not announce further reform and instead merely committed to technical reforms to make accurate payment of this charge simpler. The Chancellor also did not proceed with reforms to base the charge on household income, which would have resulted in fairer treatment for single parents.

4. 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.[9]

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 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% of doctors in the UK in the 2023, and 15% in 2022, have taken 'hard steps' to leave, compared to 7% in 2021.

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 expertise of doctors, compared to other highly qualified workers in the economy. In a recent BMA survey of NHS leavers (not yet published) when asked "Which if any of these reasons influenced your decision to leave the NHS", 36% of doctors who have left or were planning to leave in the next year selected "Pay is too low" as a reason. For resident doctors this figure rose to 73%.

While recent pay deals have helped address some of this historic erosion and the BMA is grateful for the constructive approach this Government took to negotiations with resident doctors, 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, and the government's recommendation to the DDRB of a 2.8% pay rise would be lower than RPI inflation, thereby worsening the historical pay erosion again. Doctors are also seeing better pay and conditions available elsewhere, for example in Australia, Canada, Ireland and the Middle East.[10] BMA analysis of international comparators for

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

[10] BMA Article: A world apart

different branches of practice shows a significant gap, after accounting for tax and exchange rates. Compared to working in the NHS a resident doctor can expect to earn between 16% and 34% more working in Australia, GPs between 11% and 33% more working in Canada, and consultants over 50% more working in Ireland.[11] As long as pay and conditions in the NHS remain inferior to other comparable nations, there is a significant risk of doctors leaving and reducing the likelihood of this Government achieving its manifesto commitments on general practice and 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 resident doctor pay increase, while welcome, still leaves 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, and we call on the government to consider covering any student loan repayments due while a doctor is in NHS medical employment, which would boost recruitment and retention of UK medical graduates.

Preventing the significant drop in maintenance loans for medical students in their fifth year of study is also critical for ensuring the next generation of doctors are trained. At present, medical students in England experience a significant drop in Student Finance maintenance funding as they transition into their NHS bursary funded years (from their fifth year onward). This puts enormous financial strain on students, with recent survey evidence suggesting the average medical student is £3,674 worse off per year because of the reduction in maintenance loans, while 43% of students are considering leaving their course due to financial pressures. In Wales, where students receive a full maintenance loan throughout their NHS bursary years, the majority of students report being able to cover living costs with their combined loans.

To improve access to medical training, the maintenance loan should be expanded for students in England, and additional investment should be made to maintain the NHS bursary in real terms. The cost of expanding maintenance loans is estimated at just £24 million, which would be expected to be re-paid over the course of their professional careers once these students qualify as doctors. An additional uprate to the NHS bursary, in line with inflation, should also be introduced to prevent its value being eroded. These are necessary steps to ensure that medical students can concentrate on their studies without the immense pressures that financial hardship places on them and ensuring that studying medicine remains a viable path for all prospective students, regardless of their household income.

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%.

[11] https://www.bma.org.uk/media/saajzypc/bma-evidence-submission-to-the-ddrb-202526-dec-update.pdf

Strikes have been extremely costly for everyone and must be avoided going forward. Doctors did not take the decision to undertake industrial action lightly and are acutely aware of the significant impact this has had on the operation of the NHS. In total, industrial action across all doctor groups has led to over 1.6 million procedures cancelled. 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 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 was a tremendously inefficient allocation of public money, given that it could have been better used to cover the cost of full pay restoration, which the BMA estimates at a **net cost to the Treasury of £2.7bn**.[12]

The BMA has been pleased that this government has recognised doctors' concerns and have come to the table to negotiate, but further action is needed. Whilst recent pay deals agreed represent a first step in the right direction, they still leave a considerable way to go to reversing the many years of pay erosion staff have experienced. Recent deals 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; the exact erosion varies slightly for different pay scales).

The BMA is however concerned over the Government's recent submission to the Doctors' and Dentist's Pay Review body (DDRB). Suggesting a maximum uplift in pay of 2.8%, at a time when the Office for Budget Responsibility is projecting RPI inflation to increase by 3.5% would mean yet another real-terms pay cut for doctors. The Government must continue to work constructively with the profession to recognise and address the issue of pay erosion and offer a fair settlement that promises to restore doctors pay over a reasonable period and avert the risk of further costly industrial disputes.

There is also a growing concern over the under-utilisation of the new Specialist grade contract for Specialist and Associate Specialist (SAS) doctors since its introduction in 2021. The Specialist grade was intended to offer a new route for career progression, giving experienced SAS doctors the scope to develop and practice with greater autonomy. The grade was seen as a recruitment and retention tool, as well as a means of helping employers improve their services. Unfortunately, the number of specialist positions remains limited, as they are created at the discretion of NHS Trusts. We have proposed methods of addressing this to Government, including a clear progression mechanism and a single pay spine linking the Specialty Doctors and Specialist grades. However, the expansion of the grade would necessarily require appropriate funding to fulfil one of the key original intentions behind the creation of the grade: increasing the number of doctors who can work autonomously, which we believe will materially expand NHS capacity to deliver healthcare and tackle record waiting lists.

Efforts to ensure pay restoration and to improve conditions, should also be used as an opportunity to address the gender pay gap. In England, women hospital doctors earn 18.9% less than men based on a comparison of full-time equivalent pay, while women GPs earn 15.2% less than men, and women clinical academics 11.9% less than men. We need action to address many of the systemic barriers that contribute to gendered inequalities among doctors and make provisions to ensure that women doctors continually develop and progress through their careers.

[12] This estimate is based on BMA calculations that estimate the cost of restoring the pay of secondary care doctors (consultants, SAS doctors, junior doctors) to 2008/09 levels in real terms based on RPI inflation rates up until 2024, adjusting for the increases made during recent pay-deals. While the gross cost of pay restoration is estimated at £5.5bn for this group, the net-cost would be just £2.7bn due to the additional tax revenue that would be generated

To avoid the risk of future Industrial Action, the BMA is calling for additional funding for the NHS to ensure that pay scales are consistently increased above RPI inflation with the aim of reaching full pay restoration by 2027/28. This ensures pay is more commensurate with the skills, experience and responsibility of doctors' role in the health sector and society more generally and reduces the risk of staff leaving. The Treasury should be prepared to fund commitments made as part of pay negotiations across the UK, whether on exception reporting as part of the deal made with resident doctors, or commitments secured in the SAS deal to ensure that locally employed doctors are moved to national contracts where appropriate, and where this is not possible to ensure that their employment is less precarious. Funding must also be provided to ensure meaningful uplifts that move all doctors' pay closer to the current real terms level of what it was back in 2008/09, as well as providing full funding for employers so they can afford what the Review Body on Doctors' and Dentists' Remuneration (DDRB) also recommends. 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 GP contract through adequate funding (see section 2) so salaried GPs also receive the appropriate uplift.

5. 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 commitment 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. 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 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 is especially problematic as competition for specialty training places is already at an all-time high, meaning there are resident doctors that have trained for years that are now finding themselves unemployed, while waiting lists are paradoxically mounting.

Medical school expansion, while crucial to ensuring the NHS is fit for the future and able to meet the needs of the UK's population, as well as underpinning economic growth, means this is set to get worse without action. Funding is required urgently to increase the number of specialty training places, now, as well as over the coming years. Spending on medical school expansion without an expansion of the wider training pipeline does not represent value for money, nor will it deliver the additional doctors the NHS desperately needs.

The government needs to create more specialist training places. Current bottlenecks threaten to undermine any efforts to increase the number of medical student placements, by preventing doctors from progressing in their career and risking unemployment. The current tariff for medical postgraduates is £13,377 plus market forces factor (MFF) adjustments to account for regional disparities in training costs, and a contribution to basic salary costs. Unfortunately, there is a lack of publicly available data that provide an accurate estimate of current and future demand for specialist training places. NHS England should ensure that the refreshed long-term workforce plan, due to be published this summer, includes modelling that provides insights into demand for individual medical specialities. This would allow the BMA to provide an accurate overview on what investment will be needed to deliver the necessary training, helping to improve capacity and ensuring that doctors are giving the opportunity to develop and progress their careers. The absurdity of the situation is demonstrated in a report from the Royal College of Anaesthetists. In 2024, 3,520 doctors applied for just 540 core training places, whilst at the same time the NHS is short of 1,900 anaesthetists, leading to 1.4 million operations being delayed or cancelled.

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. For a highly skilled profession such as medicine, it is essential to ensure that clinical and non-clinical medical academics are also valued and expanded in

number to teach the overt and hidden curricula underpinning behaviours and expertise of the medical profession that go beyond the acquisition of basic knowledge and skills of other occupational groups. 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. Worse still, medical academics are now also at threat of losing their jobs as a result of universities needing to make cuts given their tight funding envelopes making the situation potentially worse.

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, alongside support for universities to avoid medical academics losing their jobs, to bolster that workforce. Furthermore, any pay uplift afforded to the NHS must be matched in the academic sector to ensure these roles remain attractive. To ensure this the government's commitment to pay parity for doctors working in the academic sector 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.

During the course of this Spending Review and following the publication of the new NHS 10-year plan, a refreshed Long Term Workforce Plan will be published, so it is crucial that the Spending Review ensures key measures set out will have adequate funding attached to them.

The BMA is calling for additional investment to increase the number of medical school places from 7,500 to 10,000 by 2028. This is necessary to keep the government on course to achieve their ambition of doubling the number of medical school places by 2031. Appropriate resourcing is needed to expand the capacity of both medical schools and the NHS to meet this extra demand, while ensuring that those in training during their foundation year receive fair salaries. The Personal Social Services Research Unit (PSSRU) at the University of Kent, estimates the unit cost of training a doctor to complete their second foundation year is £378,664, which gives a sense of the scale of the costs involved with achieving this policy objective. Critically, this must be complimented by urgent efforts to increase specialty training places further down the training pipeline, to ensure the NHS has both the future doctors it needs and to avoid unemployment among resident doctors.

One area in the current 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 multiple and recurrent 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 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 and 3 years for qualified dentists 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 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, alongside the expansion in speciality and FY placements described above, to ensure patients receive safe care and unnecessary additional costs are avoided further down the line.

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

An urgent and major, one-off injection of capital investment, alongside higher levels of ongoing 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, with welcome funding commitments made in the Autumn Budget. The commitment to an additional 10.9% growth per year between 2023/24 and 2025/26 in capital funding represents a significant boost to investment. Dedicated funding to upgrade GP surgeries, improve digital technologies across the NHS, and expanding surgical capacity are critical for tackling waiting lists, improving access to primary care, and achieving the productivity aims of this government.

Unfortunately, after years of underinvestment, this barely scratches the surface. The maintenance backlog[13] has risen rapidly in recent years. Between 2015/16 and 2023/24, the cost of the maintenance backlog more than doubled from £6.3 billion to a record high of £13.7 billion. The Health Foundation has shown that while the costs of the maintenance backlog have surged, investment to address the problem has fallen by more than £700 million in real terms between 2021/22 and 2023/24.

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 cost of tackling the maintenance backlog has 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.

Critically, the deterioration in the maintenance backlog is posing a threat to the safety of both NHS 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.[14] The persistent challenges posed by the presence of RAAC (reinforced autoclaved aerated concrete) in a large number of trusts only adds to the wider problem of crumbling infrastructure and its risks to staff and patient safety.

For these reasons, the BMA is calling on the government to deliver a one-off funding injection worth £2.7 billion to address the highest risk category within the maintenance backlog.[15] Analysis

[13] 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.

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

[15] The highest risk category is considered to include urgent repairs necessary to prevent catastrophic failure or disruption to clinical services

by the Health Foundation has shown that the costs of the highest risk category have risen at a faster rate than the cost of the entire maintenance backlog, almost tripling from £1 billion in 2015/16 to £2.7 billion in 2023/24. This additional funding is essential for preventing a further escalation in high-risk costs and eliminating the threat of potentially catastrophic infrastructure failures. The Health Foundation also notes that investment to reduce the backlog fell by £707 million in real terms between 2021/22 and 2023/24. Part of the additional funding the BMA has called for to be included in CDEL budgets (see section 1) should be used to restore investment into tackling the maintenance backlog to ensure the safety of NHS staff and patients.

Lack of capital investment is undermining the delivery of primary care. Evidence from the Institute for Government suggests that one in four GPs are treating patients in surgeries that are "not fit for purpose" with a lack of consulting room that restricts their ability to employ and train GPs. Outdated IT systems and access to broadband have also been found to limit the productivity of GP surgeries. The government has recognised the scale of the challenge, and the recent funding announcement of an extra £100 million to upgrade GP estates across England is welcome. However, we need to go further. The recent Darzi Review into the NHS noted that 20% of the primary care estate predates the founding of the health service in 1948, and that the shortfall of £37 billion of capital investment into the NHS in recent years, could have rebuilt or refurbished every GP practice in the country. A sufficient proportion of the overall increase in capital budgets that the BMA is calling for (see Section 1) should be used to support a sustained and fair settlement for capital investment into primary care as a means of ensuring every GP surgery is fit for both staff and patients.

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 £3.4 bn for NHS IT improvements, which would represent 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.

The BMA views the creation of the recent reform plan for elective care for patients in England as a sign that ministers are serious about addressing the challenges facing the health service. However, new technologies and a reliance on the goodwill of staff will not be enough to deliver the reforms set out by government. We need a combination of increased investment into staff and infrastructure to ensure that the NHS has the capacity to reduce waiting lists and meet the needs of patients.

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 show that the UK only has 2.4 hospital beds per 1,000 inhabitants, compared to an OECD average of 5 per 1,000.[16] Capital investment is needed to make sure patients receive high-quality care in a timely manner.

[16] BMA Hospital Beds Data Analysis

Underinvestment in NHS infrastructure has also left the NHS with insufficient equipment, particularly critical diagnostic tools like CT and MRI scanners that are essential for 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.[17] Therefore, the government's investment of £1.5 billion for surgical hubs and scanners, alongside £70 million for radiotherapy machines is both welcome and critically important. However, it is vital that the government funds corresponding increases in the diagnostic and radiotherapy workforce to ensure that these new machines and hubs can be adequately staffed, and productivity can be maximised.

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 reassessment of The NHP (New Hospitals Programme) was needed, but a wider programme of investment is also essential. The BMA is one of many organisations that cast doubt on the NHP and its scope, funding, and timelines, and so we are glad that the government has taken steps towards ensuring that the necessary updates to the programme are made. 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.[23] [24] Therefore, although the delays to some of the selected sites are unfortunate, the new timeline for the NHP provides welcome clarity.

However, given the undeniable scale of need across the NHS, it is imperative that more expansive, system-wide, plans for improving NHS estates are also put forward (considering the findings of the 10 Year Plan which envisages more care being delivered within the community which will have implications for the NHS estate). 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 rooves 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.

[17] BMA Diagnostics Data Analysis

7. Improve mental health, population health and social care and reduce pressure on the NHS by focussing on health in all policies and increasing the public health grant

Mental health

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. 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 October 2016 (the first year that comparative data are available) and October 2024, the number of new referrals to NHS mental health services in England grew by 91% - 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. 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. We welcome the current Government's commitment to expanding the mental health workforce by 8,500 staff, but it is essential that these staff do not lead to shortages elsewhere and 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). The next iteration of the survey is scheduled for publication in June 2025, representing a 9-year interval from the previous survey due to Covid-19-related delays.

Promises to deliver on funding for mental health services have not been met. The NHS Long Term plan committed to providing mental health with at least £2.3 billion extra per year in real terms back in 2019. However, in 2023/24, real terms spending was only up by £1.4 billion compared with 2018/19. These failures have undermined the delivery of mental health services at a time when demand pressures are mounting.

The state of children's mental health services is also dire. In 2022/2023 the Children's Commissioner found that over 270,000 children that had been referred to mental health services were still waiting on support, while a further 372,800 had their referral closed before accessing support. 40,000 children had been waiting for more than 2 years to access support after referral, with waiting times varying significantly. Investment into Children's and Adolescents Mental Health Services (CAMHS) has failed to keep pace with demand and left many children in need going without treatment. This can impact their development and undermine both their long-term mental and physical health.

The BMA is calling for additional investment to tackle the rapidly rising waiting lists for mental health services. The government should ensure that the minimum pledge set by the long-term plan of at least £2.3 billion per year in real terms is met, but also that appropriate additional investment that reflects the scale and intensity of mental health needs is provided.

Public health

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. 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-19 pandemic. The Spending Review needs to ensure adequate funding is allocated to learn the lessons from the pandemic and ensure our public health functions are better resourced at both a national and a local level. It is well evidenced that public health interventions both nationally and locally offer substantial returns on investment.

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 and that it is properly ring-fenced for public health (as opposed to being used to plug potholes) and that it is properly ring-fenced for public health.

It is estimated that restoring the grant would require an additional increase of £1.4 billion real-terms per year. Taking a phased approach over a 5-year period, this would mean a total additional investment of £4.6 billion in real-terms. While at a minimum this needs to be restored, the government should look to implement a more comprehensive strategy that aims to ensure sufficient and long-term investment into public health. We recognise that responsibilities for public health are spread across many institutions, including local government, but it is vital that appropriate resourcing is delivered so the government can achieve its overall ambitions of improving population health.[18]

[18] The BMA plans on launching a report on public health and necessary investment in March/April 2025

Action on the alcohol duty is needed to reduce harm and avoid further losses in productivity. The NHS is also 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 £4.91 billion every year and wider societal costs total over £27 billion, according to a 2024 publication by the Institute of Alcohol Studies (IAS). Among those wider societal costs is an estimate of £5.056 bn in lost labour productivity due to presenteeism, absenteeism and unemployment, because of alcohol harm. In the government's pursuit of economic growth and greater productivity, it should look to alcohol harm reduction as an area where positive action should see a substantial return on investment. 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 above inflation each year. The BMA calls for the rate to be at least 2% above inflation and reviewed annually. 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 for alcohol. 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.

It is crucial that long term funding is also committed to stop smoking services across the UK to help people already smoking to quit. 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 £1.82bn 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 Tobacco and Vapes Bill aimed at tackling youth smoking and vaping, as well as the £70 million allocated to local authority smoking cessation services in December 2024, but more must be done to secure long-term funding for stop smoking services. -

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 SDIL has been successful in reducing sugar in our drinks, where the voluntary targets on industry to reduce sugar have not been. The SDIL has also 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. Expanding the levy to other products that would benefit from reformulation should be considered an important policy, along with adequate and equitable funding of 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.

Social care

Social care is a vital part of the wider health system and critical to supporting those with long-term health needs. The lack of appropriate social care services leaves many forgoing the support they need or absorbing huge financial pressures and relying on unpaid care from friends and families, regardless of the complexity of their needs. It also has a knock-on effect on the wider NHS, with many patients being prevented from being discharged back into the community despite being medically fit for discharge. It also can mean many vulnerable patients are less likely to manage their health conditions. Demand for social care is being fuelled, while NHS resources are being used inefficiently to deal with the consequences of our broken social care system, including the current corridor care crisis.

While the BMA welcomes the recent decision to establish an independent commission to build cross-party consensus on reforming social care, there remains an urgent need for action that cannot wait until 2028. The BMA flags its previous calls for an additional £7.9 billion a year in 2024/25 for social care to keep up with cost and demand pressures, as well as the need to ensure personal care is delivered free at the point of need, and additional investment to guarantee care workers a Real Living Wage as a minimum, and to improve their working conditions and training opportunities. The BMA will continue to engage with government and our colleagues across the social care sector to advocate for the necessary investment to deliver a system capable of meeting demand and ensuring that both patients and workers are treated with dignity and respect.

The social determinants of health

Poor health is often a consequence of poor socio-economic conditions. A significant proportion of the disease burden is preventable, but many are driven to adverse health behaviours by poverty, stress, and deprivation, intensifying their risk of developing chronic health conditions. Healthy life expectancy in the most deprived parts of England is barely above 50 years, meaning many in these communities will spend a significant proportion of their life in poor health. This diminishes their living standards and intensifies pressure on the health service. We need action to tackle the social determinants of health so that everyone can live in good health.