

# Funding priorities for the health and care sector: BMA's submission to the Spring Statement 2024

## 1. Introduction

- 1.1. **About the BMA.** The British Medical Association (BMA) is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding healthcare and a healthy population.
- 1.2. **This submission sets out the BMA's funding priorities over the next financial year and beyond.** Overall investment into the Department of Health and Social Care to increase NHS funding is needed (section 2), particularly to fund staff pay increases (section 3), to increase GP funding (section 6) and to improve infrastructure (section 7). In addition, further attention must be paid to financial disincentives penalising doctors from working full time – pensions and childcare (section 4) and to improving the medical training pipeline (section 5). Finally, there must also be investment into public health (section 8).
- 1.3. **Due to health being a devolved matter, the specific calls for investment set out below are England-focussed.** However, the issues highlighted are just as pressing in the devolved nations, and we would expect to see any increases in health funding mirrored for the devolved nations through the Barnett formula. These should be used directly for sorely needed spending on health services in each nation, rather than paying down debt.

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

- 2.1. **The health and care system is under significant financial pressure.** Rising prices due to inflation, ambitious elective recovery targets, and preventable strike action mean that the NHS is due to significantly exceed its planned budget: in November, the Nuffield Trust [estimated that the NHS is due](#) to overspend its budget this financial year by around £1.7 billion. Meanwhile, [waiting lists remain extremely high](#), with 7.6 billion pending treatments in November 2023 (6.4 billion unique patients). This underperformance of the NHS has significant knock-on effects to the economy and the public purse, as many people are

unable to work whilst sick. [IPPR estimates](#) that the value of bringing down the waiting list would be £73 billion over the next five years.

- 2.2. **Average funding growth for this parliament as a whole (2019/20 – 2023/24) is due to be significantly below the long-term average for funding growth.** Although total spending rose rapidly between 2019/20 and 2022/23, in large part to meet financial pressures induced by the pandemic, current plans for 2023/24 and 2024/25 reverse this trajectory. [According to the Health Foundation](#), real terms planned total health and social care spending in 2023/24 will be 3.2% or £6bn less than in 2022/23, and there are due to be no real-terms increases in 2024/25 – despite a growing and ageing population. Attempts to cut funding in this current financial year have been counter-productive, and funding pressures have meant that funding earmarked for capital improvements, vital to long-term productivity improvements and future financial stability, has had to be reallocated from capital budgets to top up day to day spending. And even despite this, millions of patients are still waiting too long to receive the care they need.
- 2.3. **In fact, under current plans, average funding growth for this parliament as a whole is due to be well below the historical average.** [Real terms average annual growth for the overall health budget in this parliament is due to be 2.1%](#), which is below the long-term average in England of 3.8% between 1979/80 and 2019/20.<sup>1</sup> Similarly, average annual growth for the NHS resource budget is set to be 3.2%, which is below the 3.4% increase envisioned in the [NHS Long Term Plan \(and these targets were set pre-pandemic – achieving the aspirations of the Long Term Plan are even more challenging post-pandemic\)](#).<sup>2 3</sup> This underfunding is putting NHS elective recovery targets in considerable jeopardy.
- 2.4. **The BMA is supportive of the principle of productivity gains, a key focus for this current health service, provided they do not come at the expense of clinical quality or staff wellbeing.** A more efficient and effective NHS is the collective goal of the government and those who work in the NHS. However, productivity gains can only be realised if they are sustainable and underpinned by sufficient funding. It is no longer sustainable to hold wages below inflation, as staff are at their limit. And the conditions in which staff work and the tools they use, particularly estates and IT infrastructure, must receive the investment promised in order for staff to be able to work effectively.
- 2.5. **Therefore, the BMA is calling for real-terms increases to both resource and capital health budgets. The resource budget for 2024/25 should increase at least in line with the historical average of total funding growth of 3.8%.** This would mean an increase to the day-to-day budget of £4.0bn,<sup>4</sup> which would allow priorities set out in the rest of this representation to be achieved, including investment in primary care, mental health and public health. As this is based on historical average growth, this does not cover additional funding needed to reverse historical pay cuts for doctors – so we are calling for further

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<sup>1</sup> These averages are for the DHSC TDEL budget.

<sup>2</sup> The Long-Term Plan promised a budget increase of 3.4% above inflation between 2019/20 and 2023/24.

<sup>3</sup> These averages are also for the DHSC TDEL budget.

<sup>4</sup> Historical average real-terms increase for DHSC TDEL budget, applied to DHSC RDEL budget excluding depreciation (for 2023/24) is £181.2bn, compared to the £177.2bn set in current plans for 2024/25 (as per the Autumn Statement 2023).

funding on top of this average growth to cover any deals negotiated (see section 3). Capital budgets need to increase significantly above the historical average, and we are calling for at least £8.1bn additional capital funding for 2024/25, due to the need for investment in infrastructure and to fix the maintenance backlog. Funds to cover doctors' pay and capital budgets must not be taken from elsewhere in the Department of Health and Social Care budget but be new and additional funding.

### **3. In order to retain doctors, be able to train the next generation of doctors and meet workforce targets, pay must be improved**

- 3.1. **Doctors feel undervalued, overworked, and burnt out.** [NHS staff survey](#) results for 2022 showed that 74% of staff are dissatisfied with their level of pay, 57% are unable to meet conflicting demands on their time, and 34% feel often or always burnt out because of their work. Staff increasingly feel that the only solution is to leave the NHS. [According to the General Medical Council](#), one in seven doctors in the UK have now taken 'hard steps' to leave, which is twice as many as in 2021.<sup>5</sup> Sadly, this exacerbates the issue. Understaffing is a major issue which itself leads to stress and reduced wellbeing creating a vicious cycle of burnout and further staff leaving. Medical vacancy rates are already high – with nearly 9,000 medical vacancies [in the NHS in September 2023](#) – and doctors often have to work in an understaffed environment. A December 2022 [BMA survey](#) found that nearly three quarters – 73% - of junior doctors 'always or frequently' work in understaffed rotas. This also puts future plans to grow the NHS medical workforce in jeopardy as it does not make economic sense to invest in training new doctors if their pay and conditions once trained are not adequate to retain them. And a particular concern is the loss of senior doctors with the skills, experience and institutional knowledge who are needed to train the next generation of doctors.
  
- 3.2. **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, which for some now means a nearly 35% real terms decline in take-home pay since 2008/09. As a result, doctor pay is no longer commensurate with the skills and experience of doctors, compared to other highly qualified workers in the economy. As the DDRB points out, in their most recent (2023) report, doctors earn "less than their other professional comparators" such as lawyers and actuaries. The recent pay scale reform offer only goes some way towards rectifying this. Doctors are also [seeing better pay and conditions available elsewhere](#), for example in Australia, Canada, Ireland and the Middle East. As long as pay and conditions in the NHS remain inferior to other comparable nations, there is a significant risk of doctors leaving.

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<sup>5</sup> 'Hard steps' includes any of the following: contacted a recruiter, applied for a clinical job abroad, applied for or attending training to prepare for a new role; applied for any other role(s) outside of medicine. This figure excludes doctors of retirement age who were planning to retire.

- 3.3. **As a result, doctors have had to make the difficult decision to take Industrial Action.** They have not done so lightly, and this has had a significant impact on the operation of the NHS this year. In total, [industrial action to date has led to over 1 million procedures cancelled](#). The [NHS' Chief Financial Officer estimates](#) that the strikes up to October 2023 cost the NHS £1 billion directly and led to a significant loss of activity with an estimated value of £1 billion in addition. This is more expensive than [our estimates](#) of Full Pay Restoration for Junior Doctors. The government has recognised doctor's concerns and have come to the table to negotiate, but we are yet to receive a credible offer for junior doctors. At the time of writing, Consultants and SAS doctors are still deliberating on whether to accept the offers put to them for 2023/24. But even those offers, if accepted, whilst a step in the right direction, would leave a long way to go to reversing the many years of pay erosion they have experienced.
- 3.4. In order to reduce the risk of future Industrial Action, the BMA is calling for additional funding for the NHS to ensure that pay scales are increased above RPI inflation in 2024/25 – and continue to come to the table with the aim of reaching full pay restoration in the near future. This will ensure pay is more commensurate with the skills, experience and responsibility for risk of doctors' role in the health sector and society more generally. The Treasury should urge governments across the UK to negotiate and commit to providing additional funding to the DHSC budget and Barnett consequential in all nations for any agreed pay uplifts negotiated with the BMA, as well as any future deals in line with recommendations from a reformed Review Body on Doctors' and Dentists' Remuneration (DDRB).<sup>6</sup> Furthermore, any pay uplift afforded to the NHS must be matched in the academic sector and for public health doctors working outside the NHS, as well as in the 2024/25 GP contract so salaried GPs also receive the appropriate uplift.

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

- 4.1. **Beyond pay, the Treasury should focus on other elements of the tax and benefits system that impacts doctors' financial incentives to work.** No doctor should be discouraged from working the maximum number of hours they want to as a result of poorly designed financial incentives. Two key issues for doctors are pensions and childcare.

### Pensions

- 4.2. **The design of the Annual Allowance tax charge and its interaction with the Defined Benefit (DB) pension scheme means more senior doctors may reduce their hours worked or reject senior responsibilities in order to avoid financial penalisation.** The removal of the lifetime allowance (LTA) and the increase in the annual allowance (AA) announced in the Spring Budget 2023 was welcome, although this was not the BMA's recommended solution to the NHS pension taxation crisis, which has forced thousands of doctors to

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<sup>6</sup> The BMA is separately calling for reform to the doctors' annual pay review body, the DDRB. We have set out the key requirements for reform [here](#), including a restoration of its independence in line with its original purpose, autonomy and authority.

reduce their hours, or to retire early. These changes will have the impact of removing the vast majority of doctors from paying punitive pension taxation bills. However, the design of the AA, particularly the taper, has not been meaningfully reformed.

- 4.3. **The change does not address the impact of the tapered AA.** The tapered annual allowance was not meaningfully reformed, 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. This means that some doctors who are impacted by the tapered annual allowance will still need to be cautious about taking on extra shifts or overtime as they may be financially penalised as a result.
- 4.4. **A further consequence of the operation of the tapered annual allowance is its impact on those who may choose to retire and return.** This group, once they combine their pension (which is taxable) and taxable retire and return earnings, will be left perilously close to the “threshold income” limit of £200k. This may provide a further serious disincentive to do additional work due to the highly punitive nature of the tapered annual allowance - providing a “tax cliff” that a member may trip over even with a single shift. It is this issue that caused many to reduce hours and retire early when the tapered annual allowance was introduced.
- 4.5. **The increase to the AA is also potentially not a long-term solution,** as there has been no assurance that the AA will be indexed to inflation. 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 similar position in a few years time.
- 4.6. **Therefore, the BMA is calling for the AA to be indexed to inflation, and for the taper to be increased significantly.** The taper itself should also be indexed to inflation going forwards.
- 4.7. **We also support the implementation of an Annual Compensation scheme for those working in the NHS.** In 2019/20, the NHS in England and Wales introduced an ‘employer based’ compensation scheme to reimburse staff for annual allowance charges. If Annual Allowance limits continue to be reduced in real terms, a cost-effective solution would be to run a similar scheme annually. It would be essential that this applied across the UK and was available to all of those working in the NHS that are adversely impacted by pension taxation.
- 4.8. In addition, the BMA supports a range of potential long-term solutions to the ongoing pension taxation issue:

- **Implement a tax unregistered scheme** similar to that offered to the judiciary. Under such an arrangement higher earners would move to this scheme once adversely impacted by pension taxation. They would then not receive tax relief on pension contributions to this scheme and contributions will be made from income on which income tax has already been paid. As there is no tax relief on contributions, there is no requirement to test the pension growth against the AA or LTA. This is not ‘special treatment’ – it simply ensures that doctors pay the correct amount of tax on pension savings and is completely fair to the taxpayer.
- **Remove the annual allowance from defined benefit schemes.** This approach would ensure that only those bound by the confines of DB schemes, usually those employed in the public sector, would benefit, unlike a more generalist approach of just increasing AA thresholds. Although the general increase in AA thresholds will resolve the issue for some doctors, it is arguably of greater benefit to higher earners in private sector defined contribution schemes. Scrapping the AA in DB schemes is also a fair approach as in the public sector, pension scheme members cannot choose how much to pay into a pension scheme as pension growth is instead linked to pensionable earnings, which is often determined by nationally set pay scales. Furthermore, in the NHS pension scheme, the scheme design also adjusts for tax relief with the higher earners paying nearly three times more per pound of pension than the lowest earners.

4.9. **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.

## Childcare

4.10. **Senior consultants, SAS doctors and GPs with childcare responsibilities face extremely high marginal tax rates due to the loss of free childcare hours and tax-free childcare.** Tax free childcare and 30 hours free childcare were introduced in 2017 with the goal of helping working parents pay for childcare. Unfortunately, the eligibility threshold meaning that any individual earning over £100,000 did not qualify, created a cliff edge for high income parents making them face extremely high effective marginal tax rates for earning over that amount. Unlike in other sectors, doctors cannot invest into their pensions to mitigate this issue, as under a defined benefit scheme they cannot vary their contribution level. In addition, the threshold disqualifying parents from accessing these schemes has not been indexed to inflation. If the threshold had been uprated with September CPI (as many other tax and benefit thresholds are), it would be £130,567 for the upcoming financial year. The BMA is calling for the threshold to be uprated and then indexed to inflation going forwards.

4.11. **In addition, the BMA believes that since the High Income Child Benefit Charge threshold has been frozen since its introduction in 2013, it is no longer fit for purpose and should be reviewed.** This charge is due once you earn at least £50,000 and that threshold has not changed since its introduction in 2013. The BMA is calling for it to be restored to the level it would be had it been uprated year-on-year by September CPI (as other benefits are) – this would mean it would increase from the current level of £50,000 to £68,461.

## 5. The Long Term Workforce Plan target to increase doctor numbers will not be achieved without a focus on the medical education training pipeline

- 5.1. **The BMA welcomes the commitment to increasing medical school places in England** by a third by 2028/29 and doubling the number of medical school training places by 2031/32 in the Long Term Workforce Plan, a commitment we have been long campaigning for. It is vital this expansion of education places is accompanied by expansion across the whole medical education pipeline – specifically in the clinical educator workforce and in the physical capacity in medical schools and in the NHS. 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 workforce is already under.
- 5.2. **The Long-Term Workforce Plan acknowledges 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. The whole health education pipeline – including physical capacity and the trainer workforce – needs to grow with some urgency. The BMA is also [concerned](#) about the impact of the proposed expansion of physician associates, anaesthesia associates and other associate roles, as well as the increase in medical apprenticeships in the plan. It is vital that training these staff does not impact on the quality of training of doctors and other existing staff groups.
- 5.3. **The Government must therefore increase the medical teaching workforce to meet increased teaching demands.** A flexible return to work programme for educators is urgently needed to bolster that workforce. Furthermore, any pay uplift afforded to the NHS must be matched in the academic sector. To ensure this the government’s commitment to pay parity for doctors working in the academic sector (life sciences) should be backed up by the funding necessary to maintain it without further reductions in posts. Finally, there should be funding for the creation of new research and educational programs that will stabilise and reverse the decline in academic FTE numbers with the goal of restoring the relative proportion of clinical academics to students and addressing the research requirements of the life sciences sectors.
- 5.4. **Beyond this financial year, the Long-Term Workforce Plan must also be fully funded.** The IFS has calculated that the [commitments in the Long-Term Workforce Plan](#) implies an annual NHS budget increase of around 3.6% per year in real terms. If the plan is not fully funded, the ambitions of the government for the delivery of services by the NHS cannot be realised.

## 6. There must be a focus on investment in continuity of patient care in community general practices

- 6.1. **Primary care, and General Practice in particular, is a vital part of the healthcare system and provides excellent value for money.** [Research has found](#) that every pound spent on

more preventative, upstream care - specifically primary and community care - correlates with a £14 increase in economic activity, more than investment in other care settings. General Practice provides excellent value for money: a single full-time GP [is now responsible](#) for an average of 2,293 patients; this is 355 more than in September 2015. This is due to an increase in the number of patients, as well as a decline in the number of GPs. Despite the reduction of GPs, they are doing more with less, and General Practice has also seen a near [5% increase](#) in activity post-pandemic whereas activity in other parts of the NHS has [decreased](#).

- 6.2. **However, investment into the GP contract has not kept up with increasing cost pressures, and GPs are under tremendous strain.** Across the 2019-24 five-year GP contract framework period, the total agreed uplifts across contractor income, staffing expenses and other expenses, has cumulatively only risen by 12.5%. Yet inflation was 21.2% between 2018/19 and 2022/23 alone – meaning that the value of the contract has been cut or eroded significantly and has been effectively cut by 7.2%<sup>7</sup>. This is putting a considerable strain on service delivery.
- 6.3. **Staffing costs in particular have risen much higher than overall investment growth.** For example, DDRB uplifts for salaried GPs have been underfunded for the majority of the 2019-24 five-year framework. For salaried GPs between 2019/20 and 2023/24, DDRB uplifts have cumulatively amounted to a 23.4% increase compared to ‘other staffing expenses’ – the element of funding that is for staff pay – which has been uplifted of 14.8%. GP practices are unable to fund the recommended DDRB uplift without support from Government and whilst practices are under so much funding pressure. This means salaried GPs have also experienced real terms earnings cuts.
- 6.4. **Therefore, the BMA is calling for an uplift to the overall GP contract funding baseline for 2024/25 in line with inflation and other cost pressures.** The BMA believes the overall contract should ideally at least be updated so that it is protected in real terms at the same level as 2019/20. This is necessary to accommodate rising necessary practice running costs and this should be put into the GP practice contract funding baseline for maximum flexibility and to allow GP Contractors/Partners to direct the funding where it is most needed. Additional funding should be provided for fair pay uplifts agreed by the DDRB in 2024/25 for employed staff, including salaried GPs and Agenda for Change Staff, to make up for many years of pay erosion and ensure staff retention / the sustainability of careers in general practice and primary care.

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<sup>7</sup> As measured by CPI. Although the BMA’s preferred measure of inflation is RPI, CPI has been used for the GP practice contract as agreed with NHSE.



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

- 7.1. **The DHSC should receive at least £20.7bn in capital funding for 2024/25** to clear the maintenance backlog and invest in the future sustainability of the NHS. This is around £8bn more than current plans. More detail about how this figure was obtained can be found in paragraph 7.9.
- 7.2. **The maintenance backlog<sup>8</sup> continues to grow year on year, and reached £11.6bn in 2022/23.** Meanwhile, investment to reduce this backlog remains extremely low: in the same year, this investment covered less than 12% of the total backlog (£1.4bn).
- 7.3. **Overdue repairs pose serious safety risks to staff and patients:** around 42% of the current backlog cost estimate pertains to [overdue repairs that pose a significant or high risk](#). This issue is reflected in the number of incidents relating to estates and facilities occurring in the NHS: [in 2022/23](#), there were on average 34 incidents per day.<sup>9</sup>
- 7.4. **The longer repairs are postponed, the more expensive they get.** Substantial upfront investment into clearing the backlog is needed not only to redress acute risks to patients and staff, but also to avoid even higher costs in the future. Over the past decade, the backlog increased by £7.6bn (188%).
- 7.5. **More capital funding is also needed to invest in the future of the NHS:** capital investment is vital to increase productivity/meet productivity targets, improve patient care, and retain staff.
- 7.6. **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](#). Yet 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.
- 7.7. **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. Capital investment is needed to make sure patients receive high-quality care in a timely manner: for example, the BMA endorses [the Royal College of Emergency Medicine's](#) call to restore the admissions to

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<sup>8</sup> 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.

<sup>9</sup> This figure is a sum of all estates and facilities related incidents (12,377) divided by 365.

beds ratio to 2017/18 levels (48%).<sup>10</sup> Bed stock in social care should also be increased so that patients can be discharged from hospital on time, [rather than occupying beds needlessly](#).

**7.8. Finally, 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.

**7.9. The BMA's ask of at least £20.7bn is based on [analysis by the NHS Confederation](#), which asks for a 39% increase in capital budgets plus funding to address the maintenance backlog. The 39% increase is based on NHS leaders' estimates of how much additional funding is needed at system level to meet productivity targets in the Long-Term Workforce plan, with corresponding increases in other capital funding areas. The resulting budget can then be kept flat until 2026/27. The NHS Confederation analysis focuses on NHS budgets only, but calls for commensurate increases in the DHSC budget. We have applied their ask for a 39% increase to the DHSC capital budget. In addition, the NHS Confederation asks for funds to clear the maintenance backlog spread over the next three years. Applied to the current backlog estimate of £11.6bn, this amounts to an additional £3.9bn per year until 2026/27.**

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

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

- 8.1. **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; 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.
- 8.2. **Demand for mental health services has increased significantly over the last few years, yet resources provided have not kept pace with demand.** Despite modest funding increases, service usage has sky-rocketed. Between 2016/17 (the first year comparative data is available) and 2021/22, the number of [referrals](#) to NHS mental health services in England grew by 44% - much lower 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.
- 8.3. **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, 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 – ie. 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).
- 8.4. **Public health should also be an important focus for investment.** A comparison of public health interventions and clinical interventions found that a public health interventions 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. Going forwards it is vital that national public health bodies are sustainably funded for routine public health functions but also adequate provisions for rapid response to largescale public health emergencies, learning from the COVID pandemic.

- 8.5. **The BMA is calling for the local authority public health grant in England to be restored to 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 – with funding for several key services cut [even more than that](#). For example, smoking cessation services were cut by 45%, and adult drug and alcohol services cut by 17%. It is vital the public health grant is restored in order that these vital preventative services can be provided adequately by local authorities.
- 8.6. **The NHS is increasingly having to bear the brunt of increases in alcohol harm as a result of increased usage and cuts to preventative services.** Alcohol costs NHS England [at least £4.2 billion every year](#). These estimates (although readjusted in December 2023 to reflect inflation) have not been revised since 2012, and are expected to be significantly higher, particularly factoring in increases in alcohol harm and drinking levels during the pandemic. Alongside the Alcohol Health Alliance (of which the BMA is a member), the BMA is calling for the introduction of an automatic uprating mechanism to increase alcohol duty by 2% above inflation at the Budget. 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. This would raise revenue, save lives, decrease harm from alcohol and ease the pressure alcohol puts on public services.
- 8.7. **The Treasury should also introduce a new commitment in the upcoming Spending Review to make improving health and wellbeing an explicit objective in every major policy decision.** The social determinants – the conditions in which we are born, grow, live and work – have a huge impact on health, and therefore nearly all policies have an impact on health. All policies should therefore be explicitly assessed in terms of their impact on health.