

About the BMA

The 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 health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

The British Medical Association is pleased to be given the opportunity to feed in to the Times Health Commission. The below submission is made on behalf of the British Medical Association and covers the following topics as outlined in the Commission's remit.

- The funding model for health and social care
- GP's and pharmacists
- Hospitals and waiting lists
- Workforce — including recruitment, retention, and training
- Obesity
- Mental Health
- The role of new technology
- Health Inequalities

The funding model for health and social care

National healthcare should be publicly funded through general taxation.

The BMA believes that national healthcare should be publicly funded through general taxation and remain free at the point of need. This is currently the case in all four UK nations, and remains an approach [widely supported by the public](#). Publicly funding health and social care through general taxation is widely considered the most equitable [approach](#): it means that contributions are proportional to income, so that those who can most afford it pay the most. Keeping healthcare free at the point of need helps ensure that those who require care can access it, which helps avoid exacerbating health inequalities.

The BMA is opposed to alternative funding models. These are often pitched by policy makers, but international comparisons of different funding models show that alternative funding models don't necessarily produce any better health outcomes. The transition between funding models is particularly [costly](#) and [disruptive](#) – resulting in additional administrative burdens for already overburdened staff. Unless there is clear and reliable evidence that changing the funding model would incur substantial and sustained improvements within the UK, policy makers should abstain from doing so.

And although *how* the system is funded is important, the *level* of funding is even more important. It is of paramount importance that the health and care system is fully funded with the amount it needs to provide high quality care for all; pay staff fairly; and ensure buildings and equipment are fit for use. The BMA does not believe this is currently the case in the NHS or social care. For example, the NHS estate is crumbling: the total cost to eliminate the maintenance backlog of existing issues alone in England stands at £10.2 billion, higher than the total annual capital budget for Health and Social care, yet the government has just announced that yet again capital budgets will be raided this year to

support Trust deficits. We also are campaigning strongly for pay increases beyond what have been budgeted, so that sub-inflationary pay cuts for doctors since 2008 can be reversed.

GP's and pharmacists

An appropriately funded, planned, and fully staffed primary care service would not only improve patient care but reduce demand and cost across the rest of the system. Primary care is central to ensuring people are, and remain, well and has an essential role as gatekeeper to access to the rest of the healthcare system. The delivery of more care in the community can help people access care closer to home and avoid having to attend hospital. This will significantly reduce overall costs as hospital care is vastly more expensive than primary care. There is evidence that strong primary care provision, which allows for continuity of care to be maintained, reduces patient mortality, acute hospitalisation, and use of out of hours services.

Currently there are simply not enough staff in General Practice. The UK has a severe shortage of GPs.

In England, while patient numbers have been increasing as of October 2023 (latest data), we had the equivalent of 1,996 fewer fully qualified full-time GPs compared to September 2015 (first data point). As of October 2023, there were nearly 62.93 million patients registered with practices in England – an average of 9,954 patients registered per practice. This is a record high. As a result, the average number of patients each full-time equivalent GP is responsible for now stands at 2,299. This is an increase of 361 patients per GP, or 19%, since 2015.

In Scotland, the number of FTE GPs has also decreased - by 5% since 2013 – and GP practices are experiencing high vacancy rates. During 2021/22, over one third of GP practices (37%) responding to the General Practice workforce survey reported a vacancy at their practice. The overall vacancy rate was 8.7%. The number of patients is also rising - in 2022, there were 5.9 million patients registered with GP practices in Scotland, 6% more than in 2013.

In Wales, the number of fully qualified, permanent GPs (headcount) has seen little growth since 2016. At the same time, the population continues to grow and age. In September 2022, the average full-time GP was responsible for 2210 patients, compared to 1676 in 2013. This represents an increase of 32% in the number of patients per full time GP – a significant increase for each individual practitioner.

While the current model of General Practice has enormous potential, it has gone from one envied around the world to one chronically understaffed, underfunded and made inefficient by successive poor national policy decisions. The independent contractor model – the model of provision which has existed since the creation of the National Health Service in 1948, ensuring continuity of care for millions of patients – works and must be preserved. However, it has been fractured in recent years and must be allowed to evolve to accommodate the increased flexibility the modern workforce seeks and to empower GPs to make the decisions and provide the services their patients need to reduce referrals, admissions, morbidity, and mortality."

The independent GP contractor model allows for the long-term relationship between patient and GPs to be built and maintained, as partners often remain stable presences in their communities and patients' lives for decades. It also allows for rapid innovation and experimentation in delivery of new services, for example, the provision of diabetes clinics, which reduce outpatient need, benefit patients, and reduce pressure on secondary care. However, due to high workload and the intense

pressures which come as part of working in a system so poorly resourced, GP partner numbers are in fairly rapid decline.

Traditionally, a career in General Practice offers doctors autonomy, the ability to provide continuity of care, variety, and the ability to work as part of a team - the key principles that attract them to become GPs in the first place. It is entirely possible to reinvigorate the profession using these principles as a basis, but it will require significant commitment from government to work with the BMA, the RCGP and NHSE to reinforce these and allow the independent contractor model to evolve and thrive. Rapidly committing to and planning for an increase in the number of fully qualified GPs as well as creating additional clinical space in GP practice through the safe expansion of existing premises and newbuilds is vital.

Hospitals and waiting lists.

Waiting lists are at record highs and continue to grow post-COVID-19

With demand for hospital treatment outstripping capacity even before COVID-19, it is unsurprising that the demands of delivering care during a pandemic have led to significant backlogs, longer waits for patients, and consistent breaches of waiting time targets.

As of September 2023, the waiting list in England stands at more than 7.7 million and consists of nearly 6.5 million individual patients. Nearly 3.3 million of those patients have been waiting over 18 weeks, while around 391,000 have been waiting over a year, approximately 254 times as many than in pre-pandemic September 2019. Similarly, the median waiting time in England stood at 14.7 weeks in September 2023, almost double the pre-COVID-19 (September 2019) median wait of 8 weeks.

While various initiatives have been attempted to reduce these waiting lists, they continue to grow. Critically, while COVID-19 undoubtedly contributed enormously to the record high waits seen since 2020, [data shows that waiting lists have been increasing steadily since at least 2011](#). Therefore, COVID-19 should be seen as having exacerbated an already existing problem, rather than as the sole cause of long waits for patients.

The BMA has been clear that healthcare estates are increasingly incapable of accommodating the delivery of safe and timely care.

As the BMA's 2022 report [Brick by Brick](#) made clear, a severe lack of capital investment has seen the UK's healthcare estates fall into deeper states of disrepair, become increasingly outdated, and in some cases pose an active risk to the safety of patients and staff. In the context of vast waiting lists and constant pressure on services, hospitals and GP practices are also frequently too small and lack the beds or equipment needed to meet demand – limiting the capacity of the UK's health services to address backlogs of care.

The BMA member survey underpinning our report keenly illustrated the poor state of healthcare estates across the UK and the ways in which this negatively impacts doctors and patients. This survey also provides important insight into the limitations of much of the existing estate. This includes challenges with regards to accommodating staff and training, the use of IT, ability to implement adequate IPC measures, staff wellbeing, and capacity for patient care – all of which must be taken into account when considering proposals for healthcare reform or transformation.

Our survey – which covered hospitals and GP practices – found that:

- 38 percent of respondents said that the overall condition of their workplaces was poor or very poor.
- 43 percent of doctors surveyed told us that the condition of their workplace has a negative impact on patient care.
- 67 percent of respondents felt that their workplace would not allow for appropriate ventilation and IPC measures in the event of a future wave of COVID-19 or another pandemic.
- 83 percent of respondents to our survey said that the condition of their place of work limits their ability to use modern equipment and technology.
- 38 percent of doctors surveyed said that the availability of break space was having a 'negative' or 'significantly negative' impact on their wellbeing at work.
- 84 percent of respondents said it had been difficult to find spaces for educational or training purposes at their place of work.

The grim findings of our survey reinforce a wide range of other reports and, in particular, national data on the condition of healthcare estates. NHS England's estates data, ERIC (Estates Returns Information Collection), showed a mammoth maintenance backlog [of £10.2bn for 2021/22](#) (data for 2022/23 is expected shortly). Data for the rest of UK showed significant maintenance backlogs of £1.08bn in Scotland (2020), £1.02bn in Wales (2022), and £1.24bn in Northern Ireland (2020), making an estimated cumulative maintenance backlog of nearly £14bn for the UK as a whole. The 2021/22 ERIC data also showed that 5,348 clinical incidents were caused by estates and infrastructure failure. These figures clearly show the extent of the underinvestment in healthcare estates and the impact it has had on patient care. While data is not available on the maintenance backlog for GP premises, it is expected to be significant, too.

The recent coverage of the presence of RAAC (reinforced autoclaved aerated concrete) in hospitals and GP practices further illustrates this point. The fact that this problem has been known about for decades but in many cases remains unresolved is indicative of the severe lack of capital investment in healthcare estates. The recent crisis surrounding the use of RAAC led to the [discovery of additional, previously unknown RAAC in parts of the estate](#) which further emphasises the extent that healthcare estates have been overlooked and underfunded.

While some investment into healthcare estates has been promised, insufficient investment and delivery have meant that little tangible progress has been made. This is exemplified by the New Hospitals Programme, which has been heavily criticised, including by the [NAO](#), the [House of Commons Public Accounts Committee](#), and many others, with respect to its funding, its scope, and deliverability. If the longstanding issues with healthcare estates are going to be resolved it will require more effective planning but, critically, must be supported with significant capital investment.

Workforce — including recruitment, retention, and training.

In comparison with other nations, England has a very low proportion of doctors relative to the population and a high number of vacant positions. Parts of the health system, including general practice, face declining doctor numbers at a time of rising patient numbers. As a result, waiting lists are skyrocketing, workloads are increasing, and doctors are burning out. In 2022, 42% 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.

Without action, it is predicted that the situation will only worsen. NHS England now estimate that workforce shortages will grow from 150,000 full-time equivalent staff members in 2021/22 to between 260-360,000 staff in 2036/37, including around 60,000 doctors.

The BMA has been warning for years now that the NHS is facing a workforce crisis, driven in large part by a lack of workforce planning and a failure to support and value staff.

The publication of NHS England's long-awaited long term workforce plan means we can start to address workforce shortages

NHS England's plan for tackling workforce shortages has some laudable aims, not least the headline commitment to double medical school places by 2031/32. The health system is desperately in need of extra doctors. To achieve its aims to recruit extra staff, the government have announced a £2.4bn commitment to fund a 27% total expansion in training places by 2028/29. However, the strategy lacks funding beyond these initial first steps, as well as a plan for implementation.

There is no value to having more students if there are no academics to teach them, nor spaces to learn in. And there needs to be guarantees that the initial expansion of medical school places will be followed by the infrastructure needed to support doctors throughout their training and into their future careers. There is currently no detail about how this will be achieved.

Extra recruitment must be accompanied by plans to better retain staff

Training new doctors will be of no avail if they don't stay in the workforce; if doctors continue to leave at current rates, it is unclear how extra trainees will be supervised, care delivered, or expertise retained. Employers, supported by government, must do more to better retain the current medical workforce. The good news is that there is much that can be done to hold on to staff, much of which would result in immediate returns. The BMA is calling for action in four areas:

- **Pay.** Restoring pay to a fair level is the first step in rebuilding good faith, showing doctors they are valued and retaining them.
- **Working conditions.** Governments, health systems and employers must act to reduce workload pressures, improve work-life balance, expand access to basic facilities and services, and stamp out harassment and abuse.
- **Diversity and inclusion.** The NHS is fortunate to have a workforce that has become more diverse over time. To keep this diverse workforce and make the most out of it action needs to be taken to end racism and discrimination and support those with additional needs to contribute to their potential.
- **Development and support.** Doctors must be able to practise in roles that make the most of their skills and experience, with the support to develop and progress personally and professionally.

Between June 2022 and June 2023, over 12,000 doctors left the NHS early in England. Unless retention is properly addressed, this is likely to get worse. In 2022, the GMC found that one in seven doctors in the UK have now taken 'hard steps' to leave, compared to one in fourteen in 2021. For every doctor that leaves, pressures worsen for those who stay - increasing the likelihood that they too will vote with their feet.

Yet current plans to better retain staff are broad, limited in detail and lack any funding to make them a reality. The biggest omission is pay and conditions. Without reversing years of pay erosion for doctors and fixing the broken pay review system, doctors will leave for better paid jobs elsewhere and we won't see the benefits of recruitment. We know that higher pay is a factor for 66% of the

doctors who want to move to practice abroad. Feeling chronically undervalued, underpaid, and overworked is forcing more and more doctors to weigh up whether to stay in the NHS. This needs to be addressed urgently to improve retention.

Doctors are struggling with their own mental health and wellbeing

Another way to improve retention within the NHS is to prioritise the mental health and wellbeing of doctors.

Mental health issues account for almost a quarter of all NHS staff absences in England, with a stark rise in staff taking sick days for anxiety, stress, and burnout since the onset of COVID-19. In total, across 2022, six million working days were lost in total to mental health and wellbeing reasons. Mental health issues were the top single-issue accounting for staff absence.

For trainee doctors, burnout levels are on the rise. Across the UK, two thirds are now at high or moderate risk of burnout, which is the highest level since the GMC started collecting this data in 2018. The same survey found that more doctors than ever said they were likely to leave the UK profession and had taken hard steps towards doing so.

Despite this, NHS England announced earlier this year it was withdrawing funding from the NHS Staff Mental Health and Wellbeing Hubs. The BMA has not been consulted on this decision, and we are yet to see a clear rationale for the decision. We are asking NHS England for more detail on how and why the decision was taken, as well as for reassurance the money used will be diverted to an evidence-based intervention to support doctors' mental health and wellbeing.

The profession is hugely concerned about the role of associates

Governments, regulators, education providers, and employers must do more to ensure that patients benefit, and doctors are not undermined, from expanding and enhancing multi-disciplinary working.

Under the government's proposed reforms set out in the Long-Term Workforce Plan, Physician Associate (PA) training places are to increase to 1,500 by 2031/32 with an aim of establishing a workforce of 10,000 PAs by 2036/37. The BMA has always supported multidisciplinary team working and recognises the crucial roles that different staff perform in the NHS. However, the government should be under no illusion that the expansion of associate roles will make up for the huge shortages of doctors. The government must not undermine the quality of care in a bid to fill gaps.

Across the medical profession concerns have also been raised that medical 'associate' roles unhelpfully blur the distinction between doctors and non-medically qualified professionals. A central tenet of well-functioning teams is that patients and clinicians have a clear understanding of the skills, qualifications and, where relevant, the limitations of those providing care. Patients should always know who is treating them and when this is – and is not – a medically qualified doctor.

[The BMA has significant concerns](#) regarding the confusion around Physician Associates. It is abundantly clear that the public find the titles of 'Physician Associates' and 'Anaesthesia Associates' highly misleading and confusing. With statutory regulation of these roles now firmly accepted, it seems logical that patients would be better protected and served by reverting to the original professional titles, to reflect their role within clinical teams.

In addition, the possibility for increasing patient confusion by expanding the General Medical Council's (GMC) remit to regulate Medical Associate Professionals (MAP) is self-evident. PAs or AAs should not be regulated by the GMC, the regulator of doctors. Doing so will only reinforce patient confusion, as the GMC's entire history is as the regulator of medical practitioners only. The point being that if confusion already exists in differentiating between PAs and doctors, regulating PAs by the GMC will only further exacerbate the problem.

The issues with MAPs go beyond professional title and choice of regulator. Their use and planned expansion challenges what it means to be a doctor, reflects how the medical profession has been devalued, and demonstrates how the health system is seeking to undermine it in favour of colleagues with less training, skills, and expertise.

[The BMA believe](#) that until there is clarity and material assurances about the role of MAPs they should not be recruited in the NHS. The Government and the NHS must urgently put in place guarantees to make sure that MAPs are properly regulated and supervised, until then, there should be a moratorium on the grounds of patient safety.

Obesity

Rates of obesity are too high in England and are a key driver of health inequalities

Two thirds of adults are overweight or living with obesity, and more than one in three children are above a healthy weight by the time they leave primary school. The NHS in the UK spends £6.5bn annually on diet-related ill health. Obesity and its associated health problems such as diabetes or liver disease pile pressure on the NHS, driving down economic productivity, and forcing thousands of people out of the workforce.

Meanwhile, in deprived communities in England, childhood obesity rates are over twice as high as in the most affluent areas. This belies considerable health inequalities, and suggests that if you are living in poverty, it is harder to keep your family healthy. Some 39% of women in the most deprived groups in England are living with obesity, compared with 22% in the least deprived groups (30% versus 22% in men). People of colour have higher obesity rates than the national average and people with learning disabilities are much more likely to be living with obesity than the general population.

The government have broken their promises on introducing policies to reduce rates of obesity.

In 2020, the UK government published their obesity strategy for England, which the BMA and other members of the Obesity Health Alliance (OHA) welcomed as a long overdue answer to our calls for a public health approach to reducing rates of obesity. Some key policies included legislating for menus to include calorie information, for a junk food marketing TV watershed, and for a ban on supermarkets offering 'buy one get one free' deals on unhealthy food. This strategy was popular amongst the public, with 8 out of 10 UK adults supporting a ban of advertising of unhealthy food on TV.

Whilst calorie labelling in some restaurants and cafes has been implemented, most of the strategy's upstream, population-level interventions with overwhelming evidence for their effectiveness have been delayed significantly. The Health and Care Bill which received Royal Assent in April 2022, and placed restrictions on advertisements of high fat, salt, and sugar foods on TV and online. However, these restrictions, as well as efforts to make it easier for families to choose healthier options in

supermarkets, have been delayed more than once and are at risk of being scrapped altogether. This is despite the overwhelming evidence for their effectiveness, as set out in the OHA's [Turning the Tide Strategy](#).

Legislation, such as the Soft Drinks Levy, demonstrate the potential of public health regulation to rapidly drive change and improve health outcomes. As outlined in the OHA's [manifesto](#), the BMA is calling for these important public health measures being implemented urgently.

Weight management services, including weight loss drugs, can play a crucial part in some people's weight loss but cannot be seen as a replacement for preventative, upstream measures.

Weight management services provide vital support and treatment for people who are struggling to lose weight. They can range from digital services that help a wider group of people, to individual bariatric surgery.

Currently, there is inequity of access to weight management services, meaning not everyone in England can access the type of service proportionate to their needs. It has been estimated that a third of Britons face a postcode lottery in accessing obesity treatment. Much of this can be attributed to a lack of primary and secondary healthcare workforce, which is needed to ensure all tiers of weight management services (Tier 1 being the most preventative tier, and Tier 4 being the most specialist service for complex obesity treatment) are available wherever you are in the country.

Meanwhile, the BMA is concerned about recent parliamentary and media attention on weight loss drugs. Weight loss drugs can be effective for some people, improving quality of life and in some cases saving lives. Scientific advances remain important, and ongoing research into the effects of weight loss drugs should be encouraged. However, there is clearly a widespread belief that they are a replacement for preventative and public health measures.

The BMA is clear, as are many others in the health sector, that there is no such replacement. Prevention is better than the cure.

Mental Health

Demand for mental healthcare is rising

The number of people with mental illness is growing. For children and young people, the latest evidence suggests that rates of mental illness may be growing at an even faster rate than amongst adults. Between 2017 and 2022, rates of probable mental disorder increased from around 1 in 8 young people aged 7-16 to more than 1 in 6. For those aged 17-19, rates increased from 1 in 10 to 1 in 4.

The number of people seeking treatment, meanwhile, has grown at a much faster rate than the number of people estimated to have a mental illness, reflecting a positive trend of more openness about mental illness and a desire to seek treatment. The percentage of adults aged 16-74 with a common mental disorder, who were accessing mental health treatment has risen from 23.1% in 2000 to 39.4% in 2014. This represents an increase of over two thirds (71%).

COVID-19 has only accelerated this trend, driving an increase in the number of people who are in contact with secondary mental health services. Mental health services in England received a record 4.6 million referrals during 2022 (up 22% from 2019), with the number of people in contact with mental health services steadily rising.

Mental health services in England are underfunded and understaffed

It is to be welcomed that more people are accessing mental health services, and this is in no small part because of a reduction in stigma attached to doing so. However, services are not currently resourced to meet the increased demand, resulting in long waits and high thresholds for treatment; latest estimates put the mental health waiting list in England at 1.2 million people (2022).

There has been a welcome increase in UK government commitments to mental health services in England in recent years, which has translated into an overall higher level of funding. However, funding is insufficient to keep pace with demand, some targets set by the UK Government's own mental health strategies are still being missed, and many people with mental illness are not receiving appropriate support (estimates put the amount of unmet need at 1.8 million people). Funding settlements for future years should be based on an assessment of the level of need and demand for services using up to date prevalence data.

The mental health workforce is not rising at the rate needed to meet either current demand or the expected increase in demand on services (due to such factors as population growth and the impact of the pandemic). Psychiatry has been an underfilled speciality for too long and despite recent gains in the trainee psychiatric workforce, there are still not enough doctors in mental health services. There are also gaps in the wider mental health workforce that need to be urgently addressed.

The average vacancy rate across England for doctors working in NHS mental health services is high with around one in seven planned FTE roles currently vacant. While all parts of the country urgently need more medical professionals working in mental health, there is considerable variation across the country, with the East of England having the lowest vacancy rate, and the Northwest the highest. The overall average vacancy rate is now higher than it was when the COVID-19 pandemic began.

Within NHS mental health nursing, the vacancy rate is even higher – standing at 21% on average across England (June 2023). This is also higher than it was when the pandemic first arrived in the UK in 2020. For all parts of the mental health workforce, true vacancy rates are likely much higher as NHS Digital figures underestimate vacancies. This is because hospitals often cannot afford to fill posts, and so vacancies are not advertised.

The role of new technology

It is, by now, a well-established reality that the provision of technology within the NHS falls well below necessary and acceptable standards. The BMA has long advocated for the use of new technology but has been clear – this cannot come at the expense of getting the basics right.

Our members have told us that the current IT they work with, particularly in secondary care, is not up to standard. In a 2022 BMA survey, just 4% of doctors across primary and secondary care reported that the software they use was 'completely' adequate and fit for purpose while just 5% indicated strong confidence that seamless and instant data sharing across the NHS will be the norm in 10 years. Functional software and effective data sharing are the bedrock of digital healthcare delivery, without them clinicians' ability to record and share vital patient information will be severely curtailed. Any discussion about the role of new technology in the NHS cannot meaningfully take place until these concerns have been addressed.

For example, the government recently announced a £250m cut to NHS technology budgets whilst spending over £300m on a new Federated Data Platform. Whilst BMA recognises the new opportunities that technological innovation can bring, without the right foundations in place – any gains will be limited.

Underpinning all new innovation is patient data – it is the lifeblood of the NHS, supporting clinical decision making, health service planning and medical research to eradicate diseases and improve healthcare. As with basic infrastructure, the future of healthcare will depend on getting the basics right. It is critical that the public and profession are properly consulted ahead of major technological changes that fundamentally alter the way data is used.

With the advent of interactive chat and imaging AI tools capturing the public imagination and within the context of rapidly growing processing power of AI models, attention on the role that they could play within the NHS has been focused. The BMA is currently exploring some of the ways that AI can deliver improvements for our members and remains committed to ensuring the highest standards of regulation for new technologies, particularly where they are patient-facing and/or involved in clinical decision making. Similarly, the BMA is keen to ensure that any large NHS data sets used to train AI models – for the purposes of developing new technologies – do not proceed without a full and proper assessment of the likelihood that they may entrench health inequalities through inherent biases present in the sets.

The confluence of these issues represents a net loss for the NHS. Nearly 71% of our members reported that current IT systems and infrastructure in their workplace “somewhat” or “significantly” increased their workload, with 58% of doctors reporting losing between 1-3 hours per week due to inefficient IT equipment. The BMA estimates that this means more than 13.5 million working hours are lost yearly in England alone due to delays as a result of inadequate or malfunctioning IT systems and equipment. This is the equivalent of almost 8,000 full time doctors or nearly £1 billion. Whilst it is critical we look to the future, there are clear and pressing problems that remain unaddressed in the present.

Health Inequalities

Health inequalities are widening as the country gets sicker

The UK was getting sicker long before COVID-19 reached the UK’s shores. The pandemic, and the government’s inadequate response, made things significantly worse. Predictably, the most disadvantaged have been most acutely impacted. Whilst health continues to improve for those in the richest parts of the country, people in deprived areas are now expected to live with ill health for longer during their shorter lives. A 60-year-old woman in the poorest areas of England has a level of ‘diagnosed illness’ equivalent to that of a 76-year-old woman in the wealthiest areas.

Millions of pounds have been cut from public services and social security since 2010, and people are dying younger as a result. The Glasgow Centre for Population Health has linked 335,000 deaths to austerity in the five years before the pandemic. With the cost-of-living crisis pushing up the cost of essential items and the value of both social security payments and wages failing to keep up, the fundamentals of a healthy life are out of reach for an increasing number of people.

As well as immense personal cost, widening health inequalities and poor health is putting the NHS and its workforce under unsustainable pressure and holding back the economy. The current situation, however, is avoidable. It is within the power of government, and indeed is their duty, to turn things around and protect the country’s health.

To prevent the country getting even sicker, it is vital that government finds a way to ensure everyone has access to the essential building blocks of a healthy life - be it a nutritious diet, a warm, damp-free home or quality care and support. This means reversing the damage caused by austerity by expanding budgets for public services so they can more adequately meet essential needs; and

exploring reforms to ensure that both social security and wages from work guarantee everyone access to the income they need to stay healthy and well.

The wider determinants of health and public health services must urgently see investment to address health inequalities.

Whilst the NHS has a role to play by, for example, diagnosing and treating illness earlier – especially among underserved disadvantaged groups – prevention must be better prioritised. The UK desperately needs more investment in the social determinants of health, and to address the drivers of ill health (such as obesity and smoking). Given the wide variety of influences on our health, neither the NHS nor the Department for Health and Social Care (DHSC) can achieve this alone. The role of professional Public Health services, which are almost all outside of the NHS, as well as wider public services, is vital.

Specialist Public Health services have a central role to play both in improving population health and ensuring the country is better prepared for public health emergencies, including pandemics. However, over the last decade, the public health system has been stripped of the resources to make best use of professional expertise, to protect and improve the public's health, to prevent illness and to inform the commissioning of local, regional, and national health services. In England, in the four years leading up to the pandemic, Public Health England's budget was reduced by 5%. Additional resources were provided to cope with Covid-19, but funding for the UK Health Security Agency (UKHSA) – which partially replaced PHE – was abruptly cut in 2022. 40% of staff lost jobs and key programmes were suspended. Locally, the public health grant received by councils has been [cut by 26%](#) on a real terms per person basis since 2015, leading directly to a reduction in both primary and secondary prevention services and specialist capacity.

The UK Government must restore the value of local authority public health grant in England. The Health Foundation estimate that restoring the grant to its historical real-terms per person value – accounting for both cost pressures and demand – would require an additional £1.5bn a year in 2022/23 price terms by 2024/25.

The UK Government is not prioritising policies which keep us well.

The BMA is calling for a stronger approach to tackling the harms caused by alcohol, nicotine and tobacco and unhealthy food and drink. The BMA welcomes the Government's recent announcements to tackle tobacco use and create a smokefree generation and these proposals should be implemented without delay. Poor diet, alcohol use and smoking all significantly increase the risk of developing several long-term health conditions. They also perpetuate health inequalities.

While rates of smoking tobacco, for example, have declined overall in recent years, they remain stubbornly high in more deprived areas. In addition, the number of people using vapes is rapidly increasing and they are being used beyond their intended use as a smoking cessation aid. Vaping is becoming particularly popular amongst children and young people, with around [4% of young people](#) (11-17 year olds) in Great Britain now regularly using vapes. This frequent use could be exposing young people to the risk of addiction to nicotine. To help address this, the BMA has called for a ban on the manufacture for commercial sale, and the commercial sale of all disposable vapes, on the grounds of disproportionate and harmful use by children and young people as well as their adverse impact on the environment.

The phenomenon of the 'alcohol harm paradox' exemplifies the disproportionate effect of harm. It shows that people living in more deprived areas are more likely to experience alcohol related harm or death, despite consuming on average less alcohol compared to those on higher incomes. For

example, people living in the most deprived areas in England are twice more likely than those living in more affluent areas to die from the direct effects of alcohol, through causes like alcohol liver disease, and effects related to alcohol intake, such as chronic kidney disease and some cancers.

Legislation, such as the Soft Drinks Levy, demonstrate the potential of public health regulation to rapidly drive change and improve health outcomes. Current measures, however, do not extend far enough. To prevent ill health, a future government should introduce fiscal measures to incentivise the reformulation of unhealthy food and drink products, phase out marketing of unhealthy items and restrict promotional tactics used to sell them, from banning advertising of unhealthy food to children and restricting multibuy offers. Such policies will tackle the high rates of obesity in England, as outlined earlier in this submission.

Gambling is also having a severe and increasing impact on the financial and mental health of a large percentage of the population and disproportionately affects those who are least able to afford it. The BMA has called for improved regulation and a public health and cross-government approach, emphasising prevention, independently funded research, better regulation, and restricted advertising, as well as increased funding for early diagnosis of addiction and effective treatment.

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