

BMA SCOTLAND
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Introduction

BMA Scotland has consistently warned that the founding principle of the NHS, that it should be free at the point of use, is at risk.

Scotland's doctors are delivering the best possible care they can to patients the length and breadth of the country and BMA Scotland is proud to represent them as their trade union and professional organisation.

We are finding however, that far too often, in our GP surgeries, hospitals and local communities, it is doctors and their colleagues who are holding together an NHS which is crumbling around them.

Without urgent action, Scotland will be a country where only those who can afford it will be able to access timely healthcare, while those less financially fortunate will be left languishing on waiting lists that are simply far too long.

While many people know someone or will have themselves been forced to access private healthcare, the evidence to support these concerns on the future of the NHS is far from simply anecdotal.

BMA Scotland commissioned research¹ which showed that almost a third of Scots (29%) say they or someone else from their household have had to use private care in the past two years.

The situation is likely getting worse, as 43% of respondents to the survey said they are now more likely to go private. This situation isn't a proactive choice either politicians or patients have made.

Indeed, evidence shows the contrary to be true, Scotland is united in support of the principle of healthcare free at the point of need and in our desire to arrest this rapid deterioration in performance of a public service many value above all others.

As we look to the next Parliamentary term, politicians must urgently deliver serious long-term and radical reform that finally puts our NHS on a sustainable footing for generations to come. There is an obligation on our leaders to do so in a way that builds consensus and brings us all together in our shared desire to protect and improve our NHS.

1 <https://www.bma.org.uk/bma-media-centre/doctors-leader-warns-nhs-is-dying-before-our-eyes-as-new-figures-reveal-scale-of-private-healthcare-use-in-scotland>
<https://diffleypartnership.co.uk/about-a-third-of-scots-have-accessed-private-health-care-for-someone-in-their-household-new-survey-finds/>





This manifesto sets out our proposals on how that might begin to happen, although there should be no suggestion that this is a quick or simple process.

For example, there has long been agreement that we need to shift the balance of where care is provided out of the acute sector and into community settings closer to where people live. The primary way to do this is through investing properly in general practice. Action must finally be taken to make this major shift a reality.

Our NHS is the people who work in it. Yet we have no proper workforce plan on how we will recruit and retain NHS staff at all levels, provide them with the rewarding, fulfilling careers they deserve and safely staff the services patients need.

How we measure what our health service does is outdated and places far too much emphasis on blunt targets that tell us little about the outcomes of people who are cared for. We need to fundamentally shift this approach; moving away from the blame culture we too often see around targets and towards shared learning and openness. Scotland needs to prioritise public health, putting in place bold measures that keep Scotland's people healthier for longer.

While these long overdue reforms are not easy and will require brave leadership and bold decisions across the political spectrum, they simply cannot be put off or ignored any longer. The people of Scotland will have their say on who they wish to lead them in the upcoming election. From that point, the pressing work of saving our NHS must begin. Alongside that, a renewed focus and clarity on supporting better health for all people in Scotland must be at the heart of all the new Government does. BMA Scotland and the doctors we represent stand ready to play our part.



CHAPTER 1: Health service delivery

Introduction

For far too long, health service delivery in Scotland has relied on an outdated model, focussed on centralised, acute, hospital-based care. Evidence increasingly suggests that this approach fails to reflect the possibilities and complexities of modern healthcare, or the efficiency and effectiveness of delivering high quality care close to where people live.

Too often, solutions to seemingly intractable issues with surging demand on secondary care have been short-term, plugging gaps where they appear rather than thinking about health and care as interacting and interdependent systems. This is why A&E performance² now reflects what used to be the worst of a winter crisis across all 12 months of a year. It is why our hospitals are stretched to the limit, operating at close to 100% capacity, without sufficient beds, while safe discharges are hampered by lack of capacity in social care. It is also why reductions in the longest waits for elective care of beyond a year are now welcomed as signs of success; no one should have to wait that long. It is why people often struggle to access GP services, with practices struggling to stay afloat³. A fundamental shift in how we deliver health services across Scotland is therefore required.

1. Shifting the balance of care

High quality, high performing healthcare systems are underpinned by a thriving primary care sector, and specifically a well-resourced and well-staffed general practice. GPs occupy a unique position as the main point of contact for patients in Scotland and are how we typically access our NHS. They can provide continuity of care, keeping the patients who they know well healthier for longer, manage multiple morbidities and prevent unnecessary hospital admissions. For far too long the proportion of the health budget provided to GPs has been shrinking, with the focus remaining on hospitals and acute care. As Audit Scotland has pointed out, GPs “manage complex care in the community, preventing unnecessary admissions to hospital. This makes an effective general practice good value for money”.⁴



2 <https://healthandcare.scot/stories/4289/royal-college-emergency-medicine-scotland>

3 <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-under-pressure-scotland>

4 General practice: Progress since the 2018 General Medical Services contract

The £250m 3-year funding deal concluded with the BMA last year⁵ provides some stability for general practice and has at last begun the process of reversing historical underfunding. It will enable practices to recruit more GPs and do more for their patients, but this must just be the start. With the proportion of the health budget provided to general practice having slipped to 6.7%, political choices must see this return to 11% by the end of the next Parliament and 15% in the Parliament after. There is no shortage of evidence of the transformative benefits such investment delivers – as the recent successful investment in identifying and managing individuals at risk of cardiovascular disease through proactive screening, risk assessment and early intervention in primary care proves. Yet in Scotland we are at the very early stages of what may be possible.

This change must be carefully managed. Secondary care provided in our hospitals is already at breaking point and the provision of safe care under threat. Simply moving resources out of the acute sector will undermine the benefits of investing elsewhere. **BMA Scotland is calling for a clear, detailed plan on shifting the balance of care to better support GPs and care closer to home while maintaining and supporting secondary care as the transition takes place and beyond.**

2. Assessing how our NHS is performing

It is vital that, as a society, Scotland uses comprehensive data to understand how our key public services are performing. Our NHS is no exception. The only way to deliver improvements or seek assurances that care is safe is to accurately measure performance and then carefully assess the results in the round to target investment to support sustainable improvement.

The issue with NHS measurement in its current form is that it too often relies on arbitrary, politically set and motivated targets to deliver stark verdicts on success and failure. This often says little about the outcomes of patients or how safe services are, which should be central to how we judge the care being provided.

New strategies and plans for the NHS should therefore include effective measurement as a key element, and this in turn should consider carefully and maturely how we record activity across primary and secondary care.



5 <https://bmascotland.home.blog/2025/10/28/deal-to-end-dispute-over-funding-restoration-accepted-by-bma-scotland-gp-committee/>

This should begin by ending the current narrative of targets entirely. From this base we should ask what we want our NHS to achieve and then set out a system of measurement that flows from those overall aims.

All measurements that we use to judge progress and target improvements should be based on four key principles:

1. Is this a realistic proposal and are the resources – both staffing and financial – in place long-term to ensure it can be achieved?
2. Is the proposal evidence-based and does it provide insight on the quality of care delivered, or patient safety and outcomes for patients?
3. Have health and social care staff been involved in developing the measurement proposal and does it allow for considered clinical input to ensure judgement of doctors is valued and relevant?
4. Does a particular measurement recognise a whole system approach – and acknowledge the potential impact on other parts of the NHS and care system across Scotland?

The days of setting targets only to let staff bear the brunt of understandable patient frustration when they are not met, must end. Doctors spend too much time apologising for and explaining why unrealistic timescales for patients, set by politicians who are thinking solely of the next set of headlines, are not met. The 12-week treatment time guarantee is a case in point, with a focus now placed on reducing the very longest waits, while this notional yet unachievable target remains in place.⁶

In areas where evidence backs up a specific measurement, for example in terms of early diagnosis of and treatment of cancer, or the fact that long A&E waits lead to substantially worse outcomes for patients, then measurement should be used to drive improvements. Equally no measurement should be seen in isolation. For example, we know A&E waits are often the symptom or warning light of pressures elsewhere in the system, so should be viewed alongside measurements such as delayed discharge or how social care is performing.

BMA Scotland is calling for a refreshed and renewed focus on how we measure the performance of Scotland's NHS, informed by wide engagement across the public and professions who work in the NHS, which ultimately puts patient outcomes at its heart and focuses on learning and improvement rather than apportioning blame.



6 <https://publichealthscotland.scot/publications/nhs-waiting-times-stage-of-treatment/stage-of-treatment-waiting-times-inpatients-day-cases-and-new-outpatients-31-march-2026/>

3. Development of a comprehensive, long-term workforce plan

Healthcare workers are the NHS. They are the true frontline, and the people who have held the service together to ensure it is in some way functional despite all the pressures placed on it.

Yet remarkably, there is no long-term, evidence-based plan on how Scotland will make sure it has the workforce required to deliver care for the people of Scotland for generations to come.

While the current Scottish Government has taken recent tentative steps to engage the medical workforce, a consistent lack of planning means that the Scottish population doesn't have the doctors it needs. This means the country faces high consultant vacancy rates⁷ as well as the counterintuitive and disgraceful position of underemployed GPs and resident doctors unable to secure specialty training places and facing unemployment.⁸ These are the most obvious symptoms of the complete lack of workforce planning that has held back our NHS for far too long.

Workforce planning is a complex and rolling process and of course will require forecasting of population health, demographic need and geographical placement across Scotland mapped alongside medical career paths and how doctors can progress through them effectively. Ultimately, it needs to ensure doctors at all stages of their careers and across all geographies and specialties are at the heart of an NHS that is sustainable in the long-term. This will potentially require difficult conversations on the scale of demand, but the reality is that without effective workforce planning we will continue to see the ongoing deterioration of services, lengthening waiting lists and the increasing reliance on the private sector BMA Scotland has warned about.

BMA Scotland calls for all parties to commit to delivering a coherent, long-term workforce plan for the NHS in Scotland to address the escalating pressures across the medical profession.



7 <https://www.bma.org.uk/bma-media-centre/bma-scotland-warns-workforce-plans-must-not-ignore-true-extent-of-consultant-vacancies>

8 <https://bmascotland.home.blog/2025/06/13/the-future-feels-quite-bleak-survey-reveals-unemployment-concerns-of-resident-doctors/>

4. Ending doctor substitution

When a workforce plan is produced it must be clear that only doctors can do the work of doctors.

BMA Scotland has consistently voiced concerns on the role of Physician Associates and Anaesthesia Associates (PAs/AAs) in Scotland's NHS and how they are used. These centre on a lack of consistency around scope of practice, the confusion that surrounds job titles, the fact these roles create additional competition for training opportunities for resident doctors as well as additional workload with doctors being asked to supervise their work.

There is a real concern that AAs/PAs will simply be used as a quick fix for the massive issues faced because of failures in medical workforce planning. Investing in additional training places for resident doctors is patently a more sustainable and safer solution than introducing substitutes for them.

Similar concerns prompted a full review in England produced by Prof Gillian Leng⁹. Key elements of the review's findings included a change in titles of these roles to reduce confusion and that they should not be seeing undifferentiated patients. **BMA Scotland calls on all parties to immediately accept the recommendations in the Leng review and confirm they would implement both of these key elements.**

Indeed, there is the opportunity in Scotland to go further and not rely on local employers to decide what is safe for these roles, and what isn't. **BMA Scotland urges the next Scottish Government to immediately commit to introducing a nationally set scope of practice for these roles.** The associated clarity that would deliver will protect patients and supervising clinicians, but it will also help those performing those roles, giving them the confidence they are acting within their competence and training. The BMA's safe scope of practice guidance¹⁰ is available to help with this, and we will continue to advocate for adoption of these parameters.



⁹ <https://www.gov.uk/government/publications/independent-review-of-the-physician-associate-and-anaesthesia-associate-roles-final-report>

¹⁰ <https://www.bma.org.uk/bma-media-centre/bma-sets-out-first-national-guidance-for-the-role-and-responsibilities-of-physician-associates-in-major-intervention-for-patient-safety>

5. Vastly improved IT infrastructure

The outdated IT systems that are still being used across both primary and secondary care in Scotland's NHS are simply no longer fit for purpose. A great deal of discussion on the future of our NHS involves the use of Artificial Intelligence (AI). While AI does have the potential to have a role in the way healthcare is delivered, we need to focus on getting the basics right first, such as an IT system that can communicate across the whole of NHS Scotland. There is no doubt that digital innovation offers huge potential to improve access across health and social care and streamline services, but it requires substantial investment and a drive to see it through long-term. There remains much to do, and areas where improvements have been far too slow in coming, such as digital prescribing. **BMA Scotland urges sufficient investment in an IT improvement plan for the whole of Scotland's NHS.**

6. An NHS that is sustainably funded to meet population needs

Many organisations and experts in Scotland have warned that the NHS is not financially sustainable in its current form – and BMA Scotland agrees. Much debate on our NHS focuses on funding and Audit Scotland again this year warned that “even with increased funding, the NHS in Scotland is not in a financially sustainable position.”¹¹

Last year seven territorial health boards required Government loans to break even – with cumulative brokerage or loans standing at some half a billion pounds.¹² This cannot continue in the long term. It is why BMA Scotland consistently called for a national conversation on our NHS and what, as a society, we want it to deliver now and in the future. Despite promises, what was delivered was not an honest and open conversation and the time has now come to move on and deliver urgent reforms, as set out in this manifesto.

The next Scottish Government must ensure that the funding and resources provided to our NHS is sufficient to meet demand now and the demand we forecast in the future, based on what we ask our NHS to deliver for patients. **BMA Scotland calls on all parties to not simply commit to more funding, but to set out clear plans on how their commitments on NHS resourcing will deliver a sustainable NHS Scotland in the long term.**



¹¹ NHS in Scotland 2025: Finance and performance | Audit Scotland

¹² NHS in Scotland 2025: Finance and performance | Audit Scotland

CHAPTER 2: Valuing doctors

We have called for a comprehensive workforce plan to ensure we have the doctors Scotland needs now and in the future, but any such plan will only work if it is supported by measures that support and value doctors at all stages of their career in medicine.

A 'whole career' focus is needed, ensuring doctors and medical students have the support they need from the moment they enter medical school, right up until when they are approaching retirement and beyond. Doctors have made a commitment to spend their career caring for the people of Scotland, and they deserve to be cared for in their career path in return.

Medical students

Scotland has a long and proud reputation of providing high quality medical education. Yet this is at risk as numbers of medical students have risen, without medical school capacity increasing correspondingly. In its recent report, 'Beyond Capacity'¹³ the BMA's Scottish Medical Students Committee highlighted this issue and the impact it is having on students along with the potential solutions.

Scotland now trains nearly double the number of medical students per head of population than England, driving congestion across undergraduate training. The goodwill of academics and doctors can only stretch so far when ward rounds try to accommodate six or seven additional students and students are forced to sit on the floor of lecture theatres to avoid missing out.

To protect the education of students and their future prospects, we must act quickly. First, we must urgently reassess student numbers to ensure class sizes support high quality education. Second, we must invest in pre-clinical and clinical training capacity, including medical academics, to properly support students. Third, we must align training positions with intake levels to restore confidence in Scotland's training pipeline and reduce the unemployment anxiety shadowing every medical student's journey.

All this must be seen within the context that Scotland undoubtedly remains under-doctored. But recruiting more students than we can train or employ will not provide the solution for this long running and deeply entrenched problem. As a result, **BMA Scotland calls for the adoption and implementation of all recommendations of the Beyond Capacity report.**



13 [Beyond Capacity – report lays bare challenges facing medical students in Scotland](#)

Medical academics

National data show that the number of medical academics has remained broadly unchanged for around two decades, leaving Scotland with similar academic staffing levels to those seen in the mid 2000s, despite a substantially larger student population.

Building on the Beyond Capacity report, medical academics play a central role in the provision of medical teaching, supervision, curriculum leadership, and the integration of research into clinical practice. A failure to fund the expansion of the academic workforce, combined with an ageing workforce and approaching retirements, further constrains the system in Scotland's ability to absorb larger cohorts of medical students safely and effectively. Without urgent action to rebuild and sustain the medical academic workforce, including ensuring their pay is protected appropriately, Scotland risks further weakening medical teaching capacity, reducing exposure to academic medicine, and posing challenges for sustaining Scotland's ambitions for high quality education, research, and evidence-based clinical practice.

Resident doctors

As part of the pay deal agreed in 2022, BMA Scotland Resident Doctors Committee and the Scottish Government are currently negotiating a new contract. This will rightly be an effective forum through which to remedy many of the issues that continue to make this stage of a doctor's career challenging and deliver on the aim of making Scotland the best place for doctors to live, work and train. Improving working conditions and protecting training time will ensure resident doctors feel valued and are the most effective ways of driving retention in Scotland, in contrast to more punitive approaches.

BMA Scotland calls for contract negotiations to continue and progress at pace post-election.

It is perhaps the single biggest failure of NHS workforce planning that Scotland faces a situation where resident doctors outnumber the specialty training places they need to progress their careers and are left fearing unemployment at a time when NHS Scotland can least afford it and patients are facing record waits for treatment. This scandal threatens to waste public money invested in educating these doctors as they give up and leave the NHS and indeed potentially Scotland altogether. In June last year a BMA Scotland survey found that 7 in 10 Scottish resident doctors were worried about unemployment¹⁴. Steps taken through Westminster legislation to prioritise UK graduates may provide some help in this respect, as will the move to WTE recruitment. **Ultimately, BMA Scotland calls for two key steps to be taken; first a substantial and appropriate increase in training places to ensure no doctor is lost to the NHS through unemployment or lack of training opportunities**



14 <https://bmascotland.home.blog/2025/06/13/the-future-feels-quite-bleak-survey-reveals-unemployment-concerns-of-resident-doctors/>

and then, longer term, the effective workforce planning that means we never again end up in such a pernicious position.

Resident doctors in Scotland, through collective strength and successful ballots, have negotiated their way to within just 6% of delivering pay restoration to 2008 levels¹⁵. In the interest of fairness, and to show that doctors are no less valued than they were 18 years ago, this final gap must be bridged and the path to full pay restoration completed. Alongside this, agreement must be reached on a mechanism to ensure that such pay erosion can never be allowed to happen again.

Specialist and specialty doctors

SAS doctors make up a not insignificant percentage of the senior doctor workforce and perform vital roles in their chosen specialties. Despite this, they are not always recognised for the substantial skill and expertise they bring and have often been overlooked. SAS doctors need to be properly recognised within the healthcare system with substantive posts and pay that acknowledges the value their branch of practice brings to NHS Scotland. Last year BMA's Scottish SAS Committee agreed a new process with Scottish Government and NHS Employers for Speciality Doctors¹⁶ to regrade as Specialists where they can demonstrate they are working at that level. This vital development will allow doctors who choose this path to progress in line with their skills and experience. **It is important that all boards deliver this process in a timely, efficient and fair manner – and we call on the next Scottish Government to maintain close oversight and monitoring to ensure it is rolled out effectively.**

As senior medics, SAS doctors experience many of the same issues faced by consultants in our NHS and are set out in the following section.

Consultant doctors

BMA Scotland's survey of senior doctors¹⁷ in Scotland exposed the level of pressure that consultants experience on a daily basis. One in four senior doctors say their workload is unmanageable and even more worryingly, the same proportion told us that services in their areas of work are normally unsafe. Our survey showed that one in three doctors aim to reduce their working hours within the next 12 months and that in 5 years' time a further third intend to have left the NHS entirely.

¹⁵ <https://www.bma.org.uk/bma-media-centre/resident-doctors-in-scotland-vote-to-accept-scottish-government-pay-offer>

¹⁶ <https://bmascotland.home.blog/2025/12/03/update-for-sas-doctors-in-scotland-new-regrading-policy-confirmed-and-survey-results-show-pressure-we-are-under/>

¹⁷ <https://bmascotland.home.blog/2025/12/03/senior-doctor-wellbeing-survey-shows-stark-reality-of-burnout-and-safety-concerns/>





We already do not have the consultants we need, with a BMA FOI showing a total of 1,165 WTE consultant vacancies across health boards in Scotland, with a vacancy rate of 16.8% – more than double the official statistics. **BMA asks that the next Scottish Government records workforce statistics adequately and honestly, reflecting the true nature of the scale of the issue for those on the ground.**

Building on that, working as a senior doctor in Scotland needs to be made both safe and sustainable. We need working patterns that don't inevitably lead to burnout and moral injury or force those with caring responsibilities to step out of the workforce. **The next Scottish Government needs to take action to retain senior doctors – ensure working patterns and work life balance are fit for purpose, modern and competitive with those in other sectors.**

Consultants are in an ideal position to offer guidance and clinical leadership, designing services that provide good patient outcomes combined with value for money. During the Covid-19 pandemic we saw NHS Scotland mobilise in an effective and efficient manner, with clinical leadership guiding that work. **The next Scottish Government must find a way to harness the talents of the senior doctor workforce to guide reform and restructure of the NHS.**



Senior doctor pay

Valuing senior doctors effectively also means restoring pay which has been lost due to years of pay erosion and ensuring the Scottish Public Pensions Agency is sufficiently resourced to provide effective support. This needs to go well beyond the poor and completely insufficient recommendations of the Doctor and Dentist Pay Review Body (DDRB). If implemented, this would be yet another real-terms pay cut.

The BMA urges the next Scottish Government to do far better than the DDRB recommendations and instead to commit to substantive talks on improving pay and working conditions.

GPs

The bulk of the £250m funding restoration deal for direct investment in general practice, agreed between the BMA's Scottish GP committee and Scottish Government, will be used to stabilise and improve the GP workforce, and help practices cope with the huge pressures being faced.

This investment fulfils BMA Scotland's key ask of funding being put directly into general practice, supporting GPs autonomy and the integrity of the independent contractor model. This is a vital shift from the Scottish Government which must be built on with the aim to increase the share of the budget provided to general practice to 11% in the coming parliament and ensure Scotland has 1 WTE GP per 1000 population.

These are ambitious aims, but they are the only way that we will end the much discussed "8am rush" for appointments. There is no doubt that this focus on core GP services and direct investment to support recruitment into the workforce is the only way to ease demand and provide the kind of access and continuity of care that patients need. This should be seen in contrast to short-term, headline grabbing but non-evidence-based initiatives such as walk-in centres¹⁸ which both experience and experts suggest simply won't work or bring the required benefits to patients.

BMA Scotland calls on the new Scottish Government to focus on an evidence-based approach to general practice, continue investing in core services and premises and commit to a shared aim of delivering 1 WTE GP per 1000 population.



¹⁸ <https://bmascotland.home.blog/2026/03/05/sgpc-money-being-put-into-frustrating-pursuit-of-walk-in-centres-would-have-been-more-wisely-invested-in-core-gp-services/>

CHAPTER 3:

Doctor wellbeing and culture

Doctors and their colleagues consistently highlight that working in Scotland's NHS negatively impacts their health. In recent BMA surveys two-thirds of consultants said that their work is harming their wellbeing¹⁹, half of GPs said they are struggling to cope and that work is having a negative effect on their physical and mental wellbeing²⁰ and some 86% of resident doctors said they were dissatisfied with their career trajectory. Virtually all anecdotal evidence in this area suggests that morale amongst the medical profession has been low for some time and is getting worse. The culture in the NHS means doctors still do not feel listened to, or that they can raise concerns without fear of repercussion.

The next Government must take action to ensure Scotland's NHS is transformed as a place to work to a place where wellbeing is prioritised and doctors are not just listened to, but their concerns acted on effectively leading to service improvements for patients.

Embedding doctor wellbeing in Scotland's NHS

Doctor wellbeing must be intrinsically linked to improving our NHS. By adopting measures set out through this manifesto, Scotland can build an NHS that performs better, is able to meet patients' needs and relies less on doctors and their colleagues working to the point of burnout and jeopardising their own wellbeing. An easing of pressure on all services will mitigate some of the more damaging impacts on doctor wellbeing, such as managing fatigue, of working in Scotland's NHS. However, there are also core and long called for measures that will reduce risk to doctors and patients and show staff they are valued.

The BMA urges the Scottish Government to improve doctors' wellbeing by implementing simple steps characteristic of a supportive employer such as; ensuring doctors are able to take scheduled breaks in high quality rest facilities, predictable rotas delivered on time, embedding safe working levels across primary and secondary care and supporting protected learning time – in particular for career development, to name just a small number of examples.



19 <https://bmascotland.home.blog/2025/12/03/senior-doctor-wellbeing-survey-shows-stark-reality-of-burnout-and-safety-concerns/>

20 <https://www.bma.org.uk/bma-media-centre/doctors-leaders-warn-government-many-gp-practices-in-scotland-are-on-the-brink>

Given the challenges of working in medicine, even with these measures, and a better performing NHS, doctors are still likely to require access to evidence-based wellbeing support. A key example is the Workforce Specialist Service (WSS).²¹ A BMA policy from 2021, this service must be protected to go on delivering specialist care for doctors and their colleagues, and all NHS boards should ensure they have well-functioning and embedded wellbeing support services which staff are able to access easily.

Embedding a learning culture in Scotland's NHS, where whistleblowers are effectively supported

It is shameful that in Scotland's NHS, evidence suggests some doctors continue to feel they cannot speak up on behalf of patients without suffering personal consequences – despite all the apparent reassurances to the contrary.²² There needs to be urgent action to better support whistleblowers to come forward, particularly younger and non-white doctors who raise concerns. NHS boards, with the clear support and backing of the Scottish Government, must do more to implement whistleblowing procedures which guarantee anonymity and protection for anyone speaking up and they must encourage reporting without fear of retaliation. We also need to see a shift in the NHS to a culture which is based on feedback and learning, not blame and finger pointing. Such a change needs to start at the very top and the new Scottish Government must focus on fostering a culture which prioritises patient safety and staff wellbeing instead of simply trying to do everything possible to manage its own reputation and that of health boards.

In light of recent issues where whistleblowers have not been listened to, BMA Scotland calls for an urgent, independent assessment of whistleblowing procedures at all NHS boards with recommendations for improvement, both for specific boards and across the NHS.



²¹ <https://wellbeinghub.scot/the-workforce-specialist-service-wss/>

²² <https://www.bma.org.uk/bma-media-centre/bullied-and-blacklisted-new-research-reveals-shocking-experiences-of-doctor-whistleblowers-in-scotland>

CHAPTER 4: Public Health

While we have set out plans in this manifesto to improve the operation of our health service, Scotland will only make substantial progress if this is coupled with robust, focussed and evidence based measures to improve the overall health of the population and the public's health literacy, enabling people to live longer, healthier lives and understand the best ways to interact with and use health services.

A concerted and strategic attempt must be made by the next Scottish Government to end the scandal of health inequalities and people's life expectancy being determined by their postcode and its relative level of deprivation²³. This will bring the added benefit of tackling the burden that poor population health places on our NHS. **Improving our NHS and improving our nation's health must be seen as joint, mutually beneficial aims and BMA Scotland calls on policymakers to acknowledge this and place it at the heart of their planning for the future.**

The Scottish Government's Population Health Framework²⁴ must not be allowed to become a project paper that sits on a shelf. It should be used to reshape, in conjunction with doctors, health and social care staff and patients, how we make sure all people living in Scotland have the right and easily accessible opportunities to live healthier lives. **BMA Scotland is clear that as a country we must make healthy choices easy choices and accessible for all. Ending the deep-rooted scandal that health inequalities present must be a priority for all politicians.**

A key step towards tackling health inequalities would be to place health as a determining factor for all policy making to ensure we prioritise the health of our nation. Health impacts all policy making, and many policies equally impact on population health. **BMA Scotland believes health impact assessment reports should be a mandatory consideration for all areas of policy making and any new legislation in the Scottish Parliament.**

Demand for access to mental health services continues to rise leading to long waits and the workforce delivering this vital care feeling exceptional pressure. These long waiting times often lead to pressures being displaced onto GPs who struggle to have the capacity and time to support this growing group of patients in the way they deserve. **BMA Scotland is calling for a renewed and refreshed mental health strategy, based on effective funding and workforce planning alongside carefully planned and focussed awareness raising campaigns.**



²³ <https://publichealthscotland.scot/publications/long-term-monitoring-of-health-inequalities-in-scotland-by-area-deprivation/long-term-monitoring-of-health-inequalities-in-scotland-by-area-deprivation/>

²⁴ <https://www.gov.scot/publications/scotlands-population-health-framework/>



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