UK 2040 OPTIONS

Health

The choices

By Esme Yates, UK 2040 Options

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Executive summary

Drawing on expert contributions and research by the Health Foundation, it's clear there are fundamental choices ahead for the next government when it comes to health.

At the top of the list is how much it invests in prevention. Projections suggest one in five people will be living with major illness by 2040. Alongside the impact on people's lives, this represents a huge cost to the NHS and to the economy. The next government can change this trajectory by targeting the causes of ill health – modifiable risk factors such as obesity – but this will take political will, changes to funding structures and incentives at the centre of government and commitment from all parts of society. The good news is the economic case is convincing, and we know what to do.

Seismic demographic shifts combined with spending constraints will require choices about how to prioritise health needs. Where should resources be directed and how should they be spread, given competing demands and varying levels of disadvantage? As with prevention, targeting health inequalities will require concerted efforts over multiple electoral cycles.

Our ageing population raises questions about social care and what is expected from governments. With the older population projected to grow by over three million people by 2040, the next government will be confronted with choices about how to support older people to live longer and live well. In addition to access and funding of social care, the role of community and the design of services will need to change.

Breakthroughs in medical technology are gaining warranted attention, but we need to harness innovation to see health outcomes and productivity soar. The choice for the next government will be to what extent – and how – it invests in the development and deployment of innovation.

But responsibility for health improvements must be shared. Business and industry play a pivotal role in creating a healthy environment. The next government can capitalise on growing momentum and partner with industry and business to address the commercial determinants of health, while making health everyone's business across Whitehall too.

These are not small questions, and the next government will need to decide how serious it is about tackling them. A meaningful shift would require changes to all parts of the system – including regulating the food environment, spending rules, the relationship with industry and the organisation of health and social care systems. The UK 2040 Options project will be tackling these choices and debates and considering policy options in more depth in the next phases of our work.

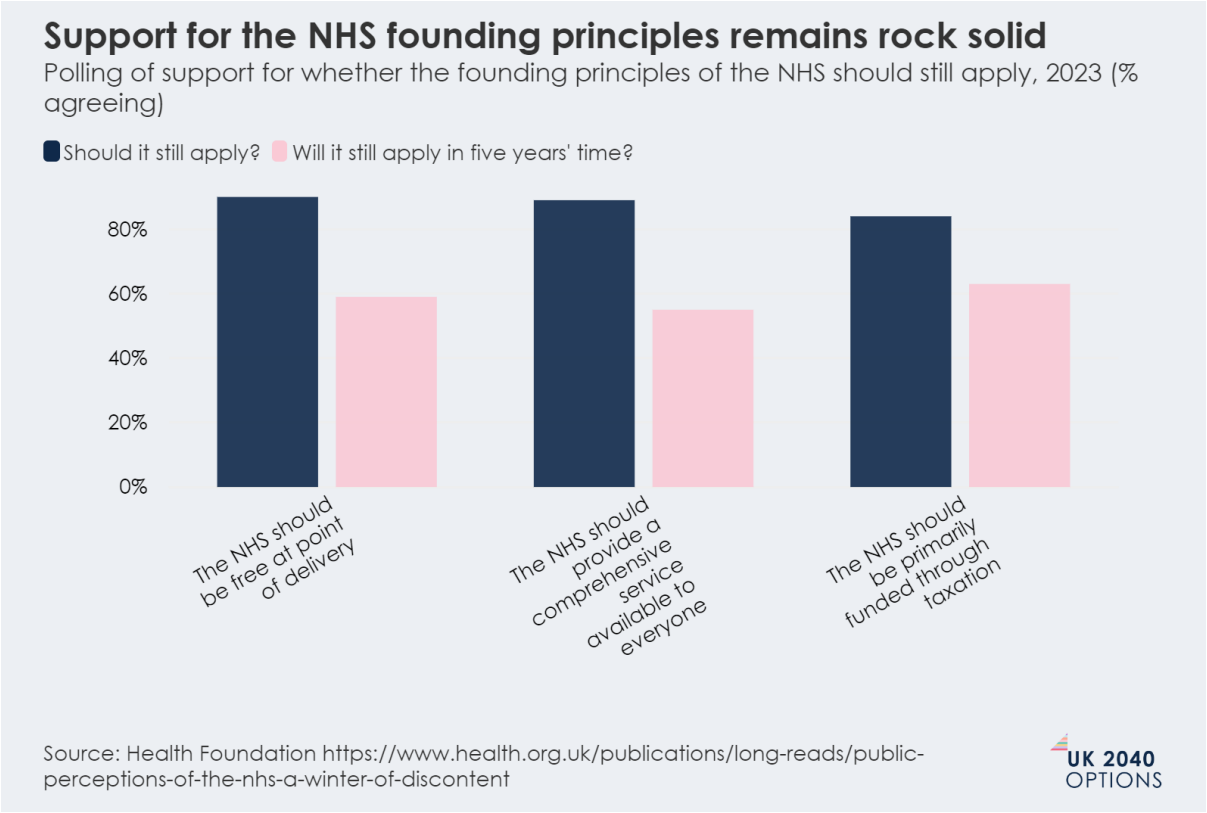
Introduction

What experts told us about the current state of health and care in the UK, and the tough choices on the horizon.

We hear repeatedly that the NHS is a system in crisis. Long waiting lists, overcrowded A&Es, and doctors and nurses on strike: these are the symptoms of a system that isn't working well for the people who work in it or the communities it serves.

Health and the NHS topped our public surveys when we asked about the biggest challenges facing the UK. The country is getting older and less well, and these seismic shifts to our demography are increasing the pressure on our already overloaded health and social care systems. It is clear that change – of some form – is needed.

At the same time, there are few things that capture the collective spirit of the British people more than our belief in the NHS. Despite its challenges in recent decades, public support for its core principles remains rock solid, with 90% of people believing the NHS should be free at the point of use.



To understand the challenges facing health and social care, and the choices ahead, we did three things:

1. **We commissioned the Health Foundation to understand the fundamental facts and trends.** Their report sets out the major challenges facing the NHS, social care and public health services in England, and outlines some implications of these for policymakers.

2. **We conducted a two-stage Delphi exercise** by surveying some of the UK's leading health and care experts and emerging thinkers to get their take on the major issues and the interventions that could help tackle them (you can find more detail at Annex B).

3. **We convened a group of leading experts** to discuss the key choices the next UK government will face.

This report on the big choices that will shape the future of health and care draws on the trends outlined by the Health Foundation, and the insights shared with us by the experts who took part in the Delphi process and in the workshop. As health is devolved, we consider policy options the UK government could pursue in England.

What we learnt

Prevention, prevention, prevention

The clear consensus among our experts is that the government should intensify efforts on prevention. We asked them to rank the suggested issues and interventions as part of our Delphi exercise, and prevention topped both lists.

This comes as no surprise: smoking and what we eat are the leading risk factors for preventable ill health and death in the UK. The NHS spends £2.6 billion and £6 billion per year respectively on smoking and obesity, and the cost to society of smoking and obesity combined could be as high as £71 billion per year. There is no reason these risk factors need to exist. Given that the NHS is already running very hot, the case for preventing these illnesses in the first place is obvious.

Prevention is also not new and enjoys broad support from across the political spectrum – from the current Prime Minister's ambition for a smoke-free generation, to Labour's vision for "an NHS where prevention comes first". We also often know what works, and advances in genomics, technology and AI could further bolster our public health capabilities. Despite this, consecutive governments continue to underinvest in prevention. So, the question is: what's holding us back? We identified three key barriers.

First, there are incentives at the core of government – including funding rules – that deter long-term investment. Often, the returns from prevention activity will only be seen decades down the line, while electoral cycles and fiscal rules can incentivise near-term pay-offs. One expert pointed out, however, that there are several areas where improvements to population health can be made rapidly, and this is where the next government should choose to focus.

Despite evidence that preventative public health interventions are both effective and cost-effective, our experts warn that successive governments' rigid, short-termist approach driven by these incentives undermines improvements in public health.

Recent announcements on meeting health professionals' pay awards within the existing health budget highlight the tendency to prioritise plugging short-term spending gaps by 'raiding' areas of spending that would deliver long-term transformational change. Although DHSC's headline budget, which includes the NHS, has risen year on year, increases have not been equally shared. The UK spends only 5% of its health budget on preventative care (excluding pandemic spending), while 60% is spent on treatment and recovery.

To put this into perspective, analysis shows for every £3,800 spent on public health, a person gains one year of life in perfect health whereas the same improvement requires £13,500 on treatments. That means public health interventions to prevent ill health are three to four times more cost-effective than treatments, yet we spend 12 times as much on less cost-effective treatments. As one expert put it, "investing in a sickness model while cutting public health funding is like coping with a flooded bathroom instead of turning off the tap".

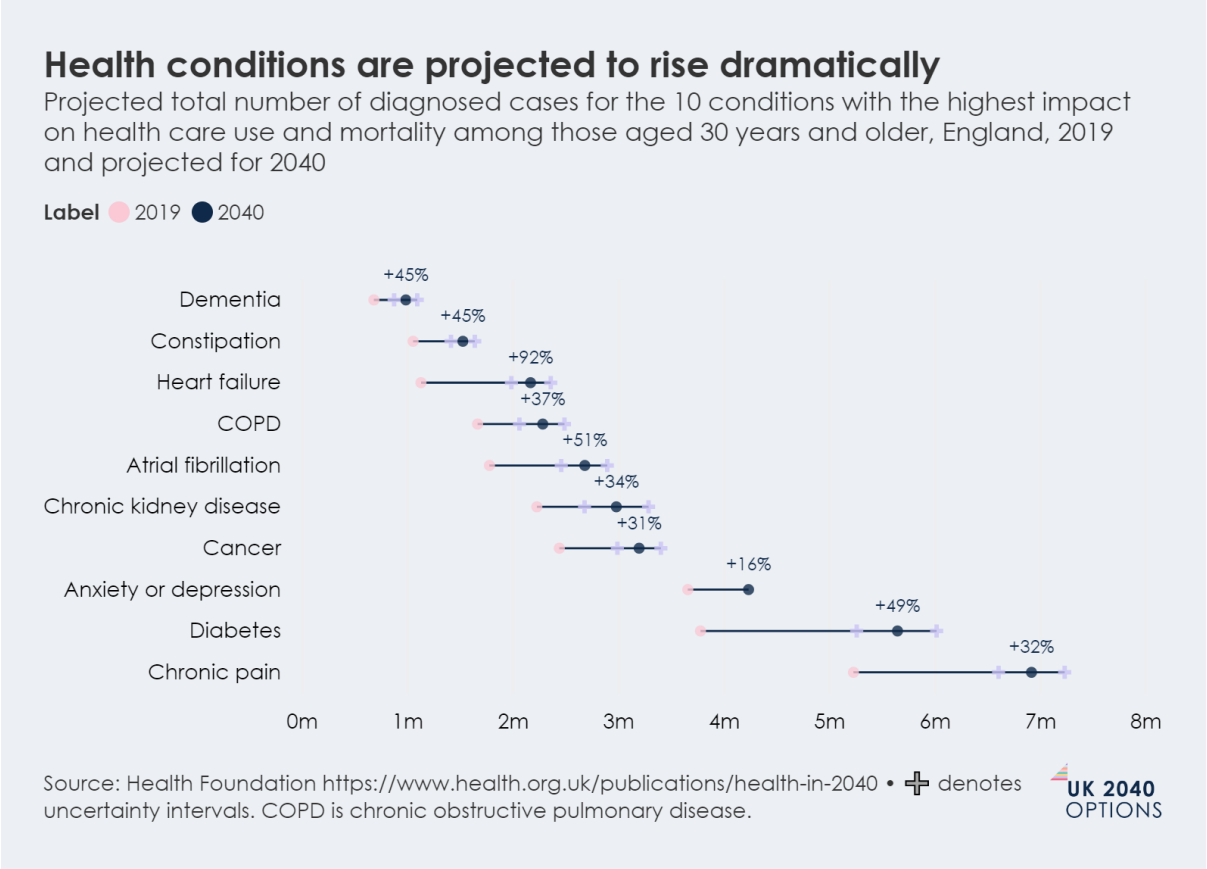
As a radical solution, the think tanks Demos and the Health Foundation have together proposed creating a new category within government expenditure to stop current fiscal rules undermining the impact of policy. Their 'Preventative Departmental Expenditure Limit' would classify and ring-fence preventative investment and provide a transparent process of budgeting and accounting for prevention spending.

But it isn't just the share of funding for prevention that's the problem. Within prevention budgets, there can be funding structures that undermine the efficacy of spend. Our experts mentioned the need to identify and iron out perverse incentives created by separate NHS and local authority funding systems for health prevention work. One thing that could make a difference is more meaningful collaboration between different parts of the health system, such as that used in the tobacco control programme in the North East and North Cumbria integrated care system. Here, the NHS is matching the money spent by the local authorities on smoking cessation programmes in recognition that both organisations will benefit from fewer people smoking.

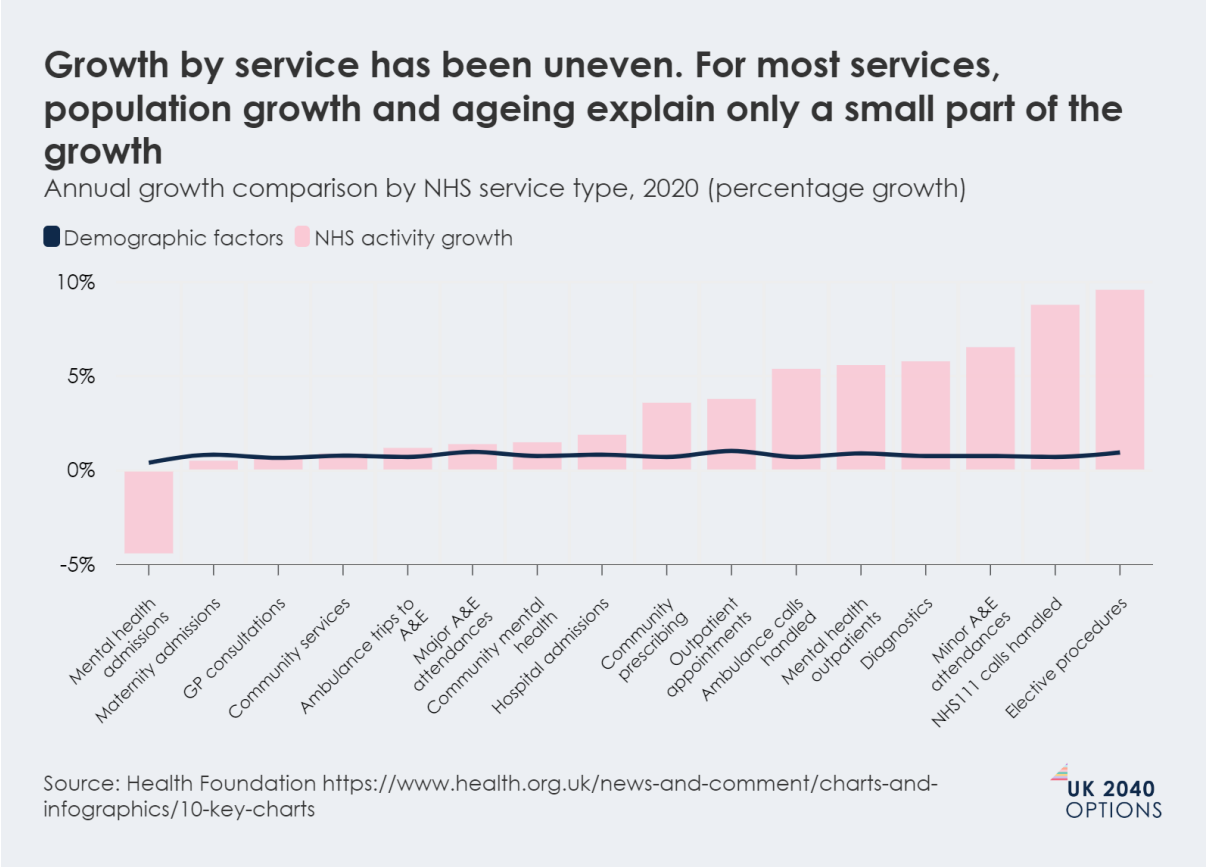
Second, while we can all agree that prevention is important, there are political challenges when it comes to the specifics. The sugar levy, which led to a 35% reduction in the sugar content of soft drinks, has been widely regarded as a successful public health measure – but it wasn't universally popular. A choice for politicians will be whether to follow or to lead the public on some of the measures that could make a difference. One expert stated that public support for an intervention was greater when framed as protecting the next generation; behavioural science shows that it's easier to prevent a habit forming than breaking one that already exists. As George Osborne, former chancellor of the exchequer, said, "no one now would reintroduce smoking in pubs, and no one now would say you shouldn't wear a seatbelt." Another expert called for more urgency; people want to live long and healthy lives, and the government needs to work with industry and communities to make it easier for everyone to make healthier choices.

Thirdly, the experts called for the government to learn from alternative approaches taken both in the UK and abroad. They agreed that shifting to a more collaborative, whole-system approach, with at least some decision-making devolved to a localised level, is sensible. This is starting to happen through integrated care systems and needs sustaining. They also suggested looking to nations that have successfully moved towards a preventative approach: Singapore's new healthcare reform was widely praised, as was Denmark's. Central to both of these is a plan to bolster primary care services and to develop a new social compact with the public to revisit what people can expect from the health service and what their responsibilities are in return.

The population the NHS serves is changing: so must it



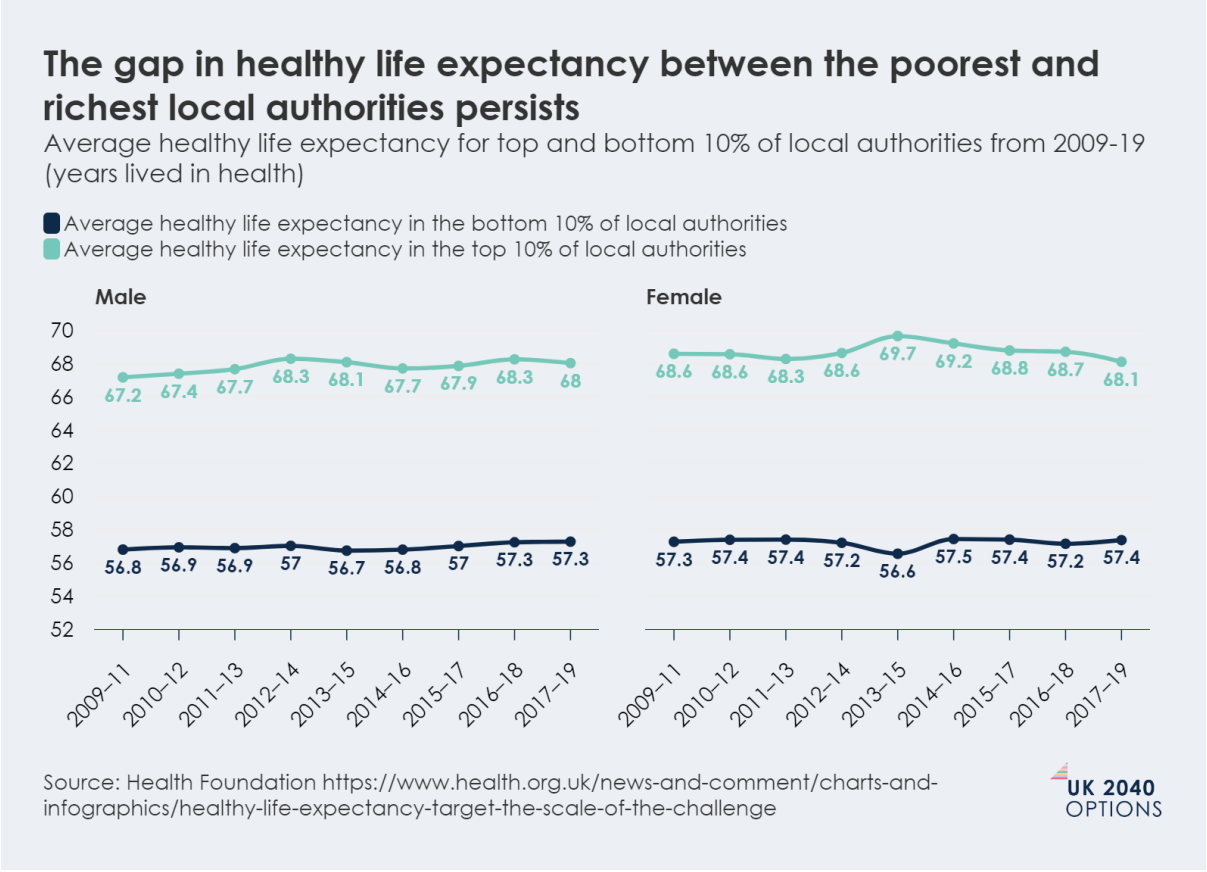
The UK population will be older and less well in 2040. Projections show the UK could have 3.3 million more over-70s than in 2019, and almost one in five adults in England could be living with major illness. These changing demographics will mean fewer people in work and more people requiring support from health and care services with major implications for the design and funding of public services. The impact of demographic changes on the users of the health service is well discussed, but our experts pointed out that it will have an impact on the workforce too, not least because most other high- and middle-income countries around the world are experiencing a similar demographic bulge, which will decrease the pool of staff from overseas that the NHS and social care services so heavily rely on.



The rise in mental ill health will also be a challenge. We know that children and young people are facing a particularly steep rise in mental health conditions; one in six children aged 6 to 16 in England had a probable mental health condition in 2021, up from one in nine in 2017. Our experts suggested the next government chooses to

focus on both the prevention of mental health conditions – particularly for children and young people – and on building capacity in the system to make services more accessible and treat people earlier. (As an aside, Nesta has asked experts to imagine some more radical solutions to addressing the surge in demand for mental health services, with provocative proposals raised, including exploring the potential of psychedelics and scaling up virtual reality treatments).

Given the challenging fiscal and demographic context, our experts considered the difficult decisions the government would need to make about whose health to prioritise. Options exist from universal access to all services — as we have come to expect from the NHS — to proportionate universalism (where universal services are delivered at a scale and intensity proportional to the degree of need), to more equity-based, targeted support for some.



Arguing for a focus on equity, one expert pointed out that the biggest gains will be found at the margins. Health inequalities are stubbornly deep-rooted and are projected to get worse. Where we're born and how we grow up, live, work and age continues to play a significant role in determining our health and life expectancy, and people from disadvantaged groups tend to accumulate more long-term conditions faster and develop them earlier (known as the social gradient). This leads to a loss of productivity and higher healthcare spend: there is a clear link between areas that have higher health inequalities and low economic activity.

It takes around 10 years of concerted efforts to achieve tangible reductions in health inequalities: the next government needs to take long-term, decisive action if it wants to reverse current trends. Our experts' suggestions include requiring integrated care systems to develop localised, integrated wellness services that focus on the most vulnerable groups, targeting local authorities with the worst health for additional funding, developing national targets for improving health for disadvantaged groups (as was done in the 2000s to some success) and increasing the number of multidisciplinary teams in primary care. Investing in health improvements for the most disadvantaged groups specifically could make the biggest difference to the overall health of the nation – boosting the economy and alleviating pressure on services.

A new offer for older people?

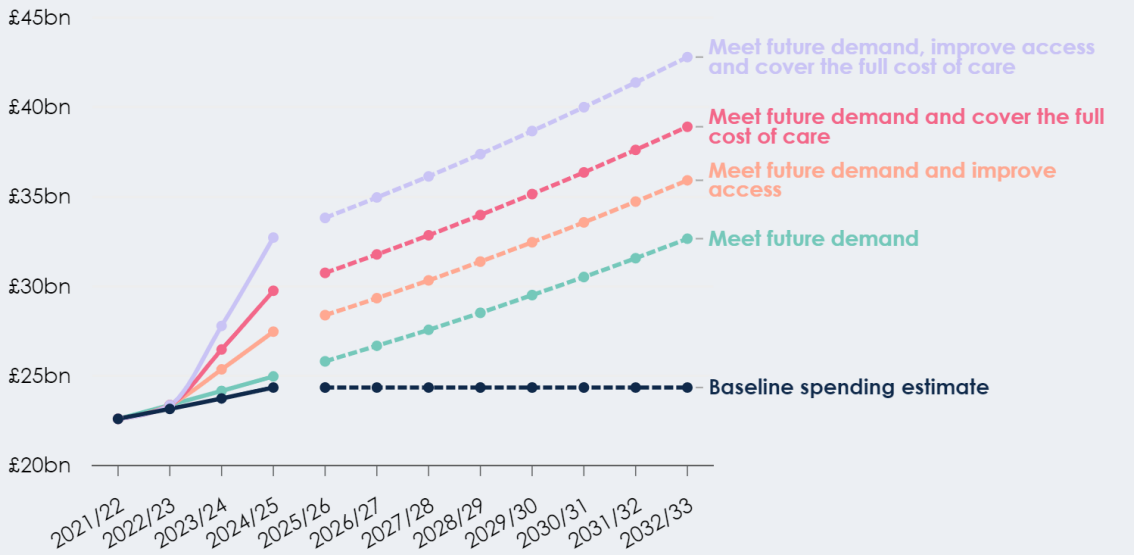
Our experts agreed that adult social care needs fundamental reform. Over 2.5 million over-50s now have some unmet need for social care, which can be so expensive that people have to sell their homes to pay for it. The workforce is also in crisis, with around one in five care workers living in poverty, and one in ten roles vacant. Although we know more and more younger adults (aged 18-64) are supported by the adult social care system, in the context of an ageing population

by 2040, our discussion with the experts focused on how the government could redesign the offer for older people.

Funding came up as the most obvious challenge. To simply sustain the current social care system without reform, the government would need to inject billions to meet the demand caused by the ageing population and growing multi-morbidities.

Meeting future demand for social care would require an additional £8.3 billion per year by 2032/33

Projected social care expenditure scenarios, 2021/22-2032/33 (in £bn)



Source: Health Foundation https://www.health.org.uk/publications/long-reads/adult-social-care-funding-pressures

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We have choices to make as a country about how to raise such large sums of money to pay for social care in a sustainable way. Should general taxation increase? Or is there the potential for a new deal with older people in which they receive better universal care but may have to give up other tax exemptions and benefits on wealth holdings that disproportionately benefit older (and wealthier) people? One idea put forward in our workshop was to consider how this money needed for higher quality care could be generated from reforms to state benefits or taxes for older people. Our work with the Institute for Fiscal Studies (IFS) on public

finances and with the Resolution Foundation on wealth and inequality has shown how wealth is concentrated in older populations and also in pension savings. One avenue to raise this money could be to reexamine inheritance tax exemptions on pension wealth or to consider charging National Insurance contributions (NICs) on pension income. These reforms would likely only impact wealthier pensioners, but could generate money to fund an improved adult social care service for all.

But our experts agreed that new cash alone won't improve the quality of social care. Rather than simply adding capacity to the existing model, future governments will need to consider other options to help people live well for longer. The Care Act 2014 has enshrined in law the promotion of wellbeing in care, but experts say there is a lot more to be done for this to translate into practice. Rather than emphasising mere longevity, one expert said the narrative should pivot towards "living well at all stages of life". Another suggested drawing inspiration from models like Buurtzorg in the Netherlands, which is Dutch for 'neighbourhood care', and is a community-centric approach that emphasises personal autonomy and social connections. We would not be starting from scratch here: there have been multiple pilots and evaluations looking at how this model could be adapted to UK settings.

There is also a wealth of evidence on how the government can make communities more age friendly, not least backed by the UN's Decade of Healthy Ageing. This includes ensuring we have appropriate housing for older people, accessible transport, and policies to tackle loneliness and isolation (an area where Nesta is looking for solutions). Future governments will need to decide how much they're willing to step back and trial new ways of delivering care to meet the changing needs of an increasingly older population, which will involve both how social care services operate and also making sure our communities are structured with the needs of older people in mind.

Unlocking productivity through innovation

Healthcare professionals are already experts in achieving more with less due to long-standing resource constraints. But smart adoption and deployment of innovation could boost productivity – if it is implemented properly.

Our experts pointed out that the NHS has a strong track record on productivity: between 2004/2005 and 2016/17, productivity increased 2.5 times compared to the rest of the UK economy (although from 2011 onwards, this was due to limiting wage growth). Yet, despite there being a record number of staff in recent years, productivity has not gone up proportionately for a number of reasons, including patients presenting with more complex and intense needs, high staff turnover, lack of investment in capital and equipment, and lack of managers. With constant pressure to do more with less, finding ways to improve efficiency and productivity will continue to be high on the agenda for the next government.

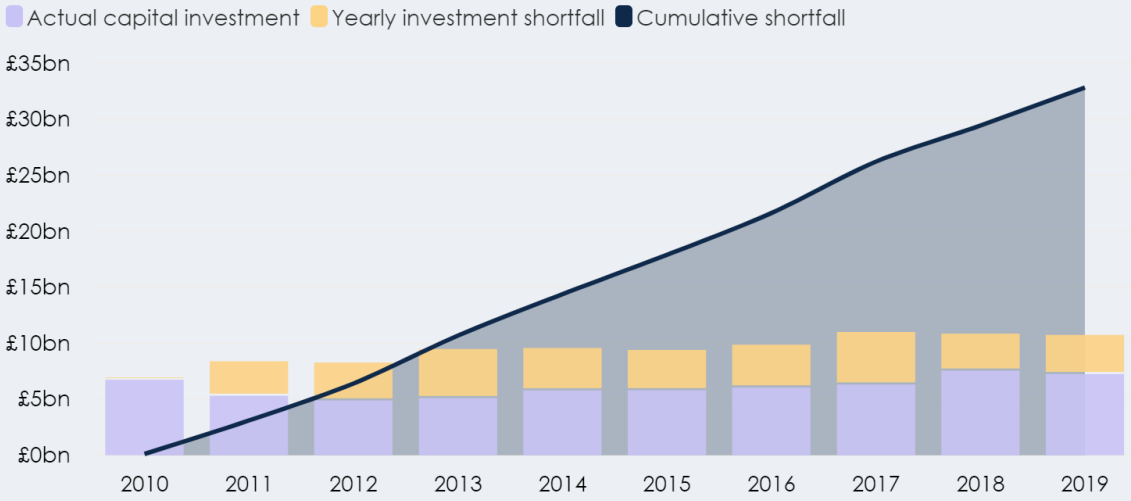
Our experts were clear that innovation would be crucial for both treatment and productivity improvements between now and 2040. Innovations range from new medicines, to new technologies (like using AI to speed up radiologists work by up to 25%), to new models of care (like virtual wards). One expert warned of the risk that diagnostic advances, such as personalised genomics, might inflate rather than meet demand. To combat this, and ensure any transition to a more technology-enabled system is effective, experts agreed that a forensic level of management is required in order to understand what is happening at the clinical level.

The choice for the government will be to what extent – and how – it invests in enabling the take up and spread of innovation, with experts suggesting options from top-down big demonstrator approaches for new technologies, to giving integrated care systems autonomy to make changes based on local needs. Everyone agreed

there isn't a one-size-fits-all solution; success will depend on how the change is managed, and will require time, space, sufficient resources and, very often, shifts in culture and behaviour at a local level. None of this is easy, but the message was clear: the government will need to choose to accompany any 'shiny' announcements on new innovations with sufficient resources to adopt and scale them, if they are going to make a real difference to patients and staff.

The UK would have invested £33 billion more in healthcare capital between 2010-19 if it matched the investment levels of other major EU countries

Total UK health care capital investment and cumulative shortfall compared to other EU14 countries, 2010–2019 (£bn)



Source: Health Foundation https://www.health.org.uk/news-and-comment/charts-and-infographics/how-does-uk-health-spending-compare-across-europe-over-the-past-decade

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Underpinning this will also be capital investment. The gap between how much the UK and other OECD countries spend on capital is striking, and this has a cumulative impact on how well the NHS estate functions and how ready it is to "go faster". Our experts were clear that if future governments want to meet the current vision for a world-leading technology- and data-driven health and care system, this would need to be supported with a long-term, funded, capital plan.

How much the government chooses to invest, how that money is allocated and what rules are set to control how Trusts spend that money will determine to a large extent whether the NHS can adopt the innovations that could make their services more productive.

Health is everyone's business

There is consensus that it cannot fall to the taxpayer alone to pick up the bill for health; business and industry play a pivotal role in creating a healthy environment, from how they treat their employees to what they sell.

The relationship between work, health and unemployment is complex. We know that good-quality work can be good for health, and being out of work can be bad for health; a staggering 54% of unemployed people suffer from poor mental health. But having a job doesn't always mean a better life; nearly 60% of people in poverty live in a household where someone works. Whichever way you look at it, the links between work and health are strong, and if the aim is to have a healthy, thriving population, there are options both government and business can consider to support employees' health at work, get unemployed people back into work, and – crucially – improve the quality, security and pay of jobs available.

Our experts also suggested options for addressing the commercial determinants of health. It's a tough balance to strike: the government has laws in place to protect customers, but they also don't want to make it too hard for businesses to follow the rules. How much should industry behaviour be regulated? Where are there gains to be had and where are there vested interests? How can regulation improve health without putting additional unnecessary costs onto consumers? In the food industry, one route for this is setting mandatory targets for standards to be met, with fines for breaches. The intention is that this leads to improvements in practice rather than

fines being paid, and the nation gets healthier. Nesta has modelled what a mandatory target for health could look like for supermarkets.

Finally, our experts believed that health should be everyone's business inside government too. They ranked poverty, housing and educational inequalities as top issues to address to improve health outcomes by 2040 – which are all areas that exist outside of DHSC control. A cross-Whitehall strategy on the wider determinants of health was floated as an intervention that could have a serious positive impact (and Labour have pledged a national framework to embed health in all policies). But experts argued that it would need both clearly agreed macro ambitions and specific, measurable targets, to be more than a tokenistic attempt. Accountability will be key: a broad-brush 'strategy' could let everyone off the hook, but clear targets for DHSC, the NHS and other organisations and departments could make a real difference.

Conclusion

Designing services to meet the needs of an older population with more complex health needs in 2040 will not be an easy task, and the wide range of issues and solutions that our experts raised in the Delphi process and in the workshop demonstrated just how challenging it will be.

Experts universally agree that we need to switch funding away from plugging short-term gaps towards investing in long-term sustainable change. But funding is not a silver bullet. Even if we increased funding to match the OECD average, improved working conditions, filled every staff vacancy and provided timely, high-quality care for every patient – it would still not be enough to put health and social care on a stable long-term footing. Why? Because this does little to adapt to the shifting tectonic plates of the UK's demography and rising tide of illness. Without fundamental reform to truly stem the tide of ill health, costs will continue to rise

exponentially, making the whole system unaffordable and threatening the founding principles of the NHS.

The next government will therefore need to choose how seriously it is prepared to shift to a preventative approach, and whether it is willing to make changes to all parts of the system – from regulating the food environment, to spending rules, to its relationship with industry, to how it organises health and social care systems – if it is going to achieve meaningful change.

The UK 2040 Options project will be tackling some of these choices and debates, through considering policy options in more depth, in the next phases of our work.

Roundtable participants

We sincerely thank our workshop participants for their time and contributions. Please note that not all participants will have agreed with all the discussion points above.

Ben Jupp – NHS England
Professor Bola Owolabi – NHS England
Professor David Halpern CBE – Behavioural Insights Team
Dame Gill Morgan – Gloucestershire Integrated Care Board
Dr Jennifer Dixon – The Health Foundation [Chair]
Professor Sir Jonathan Van-Tam – University of Nottingham
Jason Yiannikkou – DHSC
Nancy Hey – What Works Centre for Wellbeing
Ravi Gurumurthy – Nesta
Richard Murray – The King's Fund
Professor Dame Theresa Marteau – University of Cambridge
Professor Vic Rayner OBE – National Care Forum

Annex A: Fundamental facts

Health: the Fundamentals

Annex B: Delphi detail

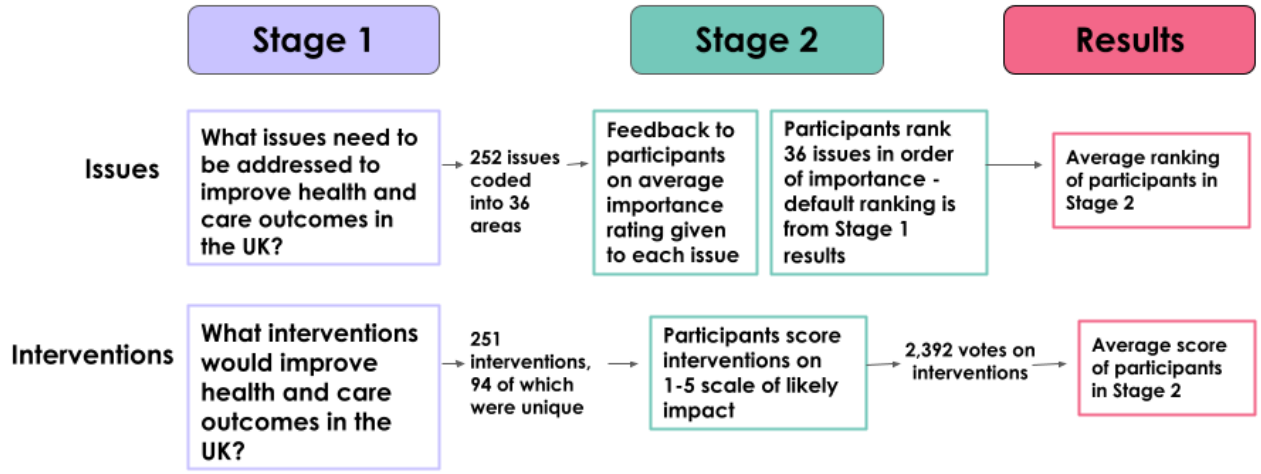
What is a Delphi exercise and how have we run them?

Delphi exercises allow us to get collective deliberation from a group of people – in this case it is the most important issues and impactful interventions in health and care in the UK.

A Delphi exercise involves asking for expert input or opinion, feeding back what other respondents said and then allowing respondents to revise their judgements or opinions. Opinions are kept anonymous throughout.

Our Delphi exercise included two rounds. In round one, we asked respondents about the issues and interventions that could impact health and care outcomes, and asked how important each of them are. In round two, we fed these issues and interventions back to the respondents alongside their average importance score before asking the panel for their final judgement.

Our final results are the average scores given by experts in round two.
This process can be seen in the below diagram.



For more on the Delphi method, see information from Rand and the British Medical Journal.

Full list of issues identified in order of perceived importance (most important at top)

1. Not enough focus on prevention
2. Rates of poverty are too high
3. Poor diet and obesity
4. Health inequalities
5. Underfunding of public services and healthcare, including public health

6. Insufficient access to primary care due to underfunding and/or capacity
7. A lack of access to social care resulting from underfunding and low capacity
8. Lack of affordable and/or quality housing
9. Underinvestment in capital
10. Poor technology and data infrastructure
11. Poor working conditions, low morale and failure to retain staff
12. The influence of commercial interests and industry, including through advertising
13. Lack of effective care for chronic diseases
14. Early years and education inequality
15. A failure to focus on outcomes as opposed to processes and outputs
16. Ageing population
17. Too much focus on the short term
18. Low pay across health and social care
19. Poor or ineffective governance and leadership in the health and care system
20. Health and work: low-quality work, unhealthy workplaces or unemployment
21. Smoking
22. A lack of continuity of care for patients
23. Lack of clarity on the overall purpose of the health service
24. Impact of Brexit
25. Impact of the environment on health
26. Need for social care reform
27. Need for more effective devolution of power from central government
28. Poor integration of health and social care
29. Inefficiency and poor productivity in healthcare
30. Inadequate screening/early detection
31. Lack of robust and resilient local health protection system
32. Low vaccination rates
33. Limited access to justice for community care issues resulting in lack of accountability for public bodies
34. Presence of corruption and misdirection of resources
35. The public has too-high expectations of what the NHS can achieve
36. A need for more patient involvement and empowerment

Full list of interventions identified and their perceived impact, most impactful at top, average impact score out of five

These were the potential interventions identified by participants that would improve health and social care outcomes in the UK.

1. Invest more in public health and prevention
2. Develop a cross government plan on wider determinants of health (social, economic, transport etc.)
3. Extend the sugar tax
4. Address the commercial determinants of health and vested interests of companies selling products that do harm
5. Designate a larger part of the health budget for primary care and prevention
6. Introduce tiered taxes on health damaging products and services so as to stimulate reformulation/reconfiguration
7. Control unhealthy food advertising through legislation
8. Increase the smoking age to 21 and then raise it year on year
9. Invest more in schools and early years, particularly in deprived areas
10. Invest more in social care
11. Introduce minimum alcohol prices
12. Increase capacity in mental health services
13. Increase the real value of the public health grant
14. Invest in good-quality social housing
15. Stop annual budgeting and move to multiyear investment approach
16. Add health as explicit due consideration for planning laws around trade/transport/other major infrastructure projects
17. Develop clear accountability for outcomes across systems
18. Mandating reporting by food industry on health relevant metrics
19. Invest more in public services
20. Resolve industrial action
21. Develop a capital plan for the NHS and fully fund it
22. Improve cross government working on children and child poverty
23. Rethink chronic disease prevention and care
24. Implement Khan Tobacco Review
25. Promote smoking cessation
26. Create legally enforced data standards to allow for total interoperability of data sets across healthcare
27. Overhaul and expansion of the Healthy Start scheme to give more support (money and skills) for a healthy diet to families with young children

28. Rationalise/clarify responsibilities around prevention across the system
29. Reinstate Sure Start
30. Spend 10p in every £1 extra NHS funding on public health to restore public health grant
31. Include health objectives and tradeoffs methodology in tax policy design
32. Increase diagnostic capacity
33. Adhere to the alcohol strategy
34. Introduce a more comprehensive and generous welfare state
35. Eliminate variation in clinical access and practice across the country
36. Fund and implement the NHS workforce plan
37. Ensure a minimum income guarantee for healthy and sustainable living
38. Increase provision of mental health and wellbeing support in schools
39. Produce a workforce plan for social care
40. Reform social care pay to match NHS rates and terms
41. Introduce whole school food policies to change food culture, not just school lunches
42. Reform zoning and planning laws to reduce the density of fast-food outlets in urban areas
43. Pause any NHS reorganisation for the next five years
44. Develop a new model of primary care/out of hospital care
45. Devolve resources to local government with inequalities weighting
46. Introduce a minimum income guarantee for families with children
47. Restrict vehicles near vulnerable settings (schools, built-up areas etc.) to improve air quality
48. Increase the number of health and care visas
49. Create clearer and significant incentives for improved productivity across the health and care sector
50. Implement free school meals for all children
51. Rejoin the EU
52. Improve capital funding allocation mechanism to encourage funds to get spent
53. Increase pay
54. Roll out insulation and sustainable heating/cooling retrofitting schemes
55. Increase 'NHS at Home' and remote clinics
56. Draw on the learning from Healthy Schools programmes to mandate what works
57. Increase continuous professional development for the workforce
58. Remove two-child benefit cap

59. Reform professional regulation to facilitate micro credentialing, allowing healthcare tasks to be completed by the right person, not siloed to specific professions
60. Fund specialist weight management services
61. Make school exercise compulsory
62. Shift the workplace culture to staff support
63. Ban buy-one-get-one-free deals
64. Align more closely with the EU
65. Provide better community support for new parents
66. Focus on reaching net zero
67. Legislate based on proportionate universalism
68. Develop a national strategy for wellbeing
69. Create more comparative data on efficiency of services (similar to Getting it Right First Time)
70. Reorganise medical postgraduate training
71. Provide affordable gyms and leisure facilities
72. Expand screening capacity
73. Increase the number and quality of managers, remunerated in line with their importance
74. Replicate Wales' the Wellbeing of Future Generations Act
75. Increase social prescribing
76. Create financial incentives to lose weight and exercise more
77. Create clearer governance structures with regions/integrated care boards and increasingly remove trust independence
78. Introduce outcome-based reimbursement for medicines in the Innovative Medicines Fund
79. Launch a public campaign to increase acceptance of self care for minor self-limiting illness to free up primary care capacity to focus on more severe illness
80. Nationalise key utilities and services to improve efficiency and stem profiteering
81. Create a national mission to invest in and develop trusted, safe healthcare AI solutions
82. Increase the number of admin staff
83. Simplify local authority governance over the NHS
84. Extend the Disabled Facilities Grant
85. Invest in wastewater and genomics testing to develop a modern health protect surveillance system

86. Devolve transport budgets to metro mayors/combined authorities
87. Improve the NHS app
88. Require every Integrated Care System to develop an Independent Living and Prevention Strategy
89. Invest in local resilience forums' outbreak management surge capacity
90. Make NHS pensions less generous (or at least more flexible) and use it to top up pay
91. Give NHS the responsibility for providing adult social care
92. Revoke 'minimum service levels' legislation
93. Allow patients to choose any GP in an ICS
94. Move some NHS services into the realm of private healthcare or co-payment

UK 2040 OPTIONS

UK Options 2040 supports policymakers as they make choices about what to prioritise and how to deliver: setting out alternative policy options and pathways for the future, creating space for honest debate about the trade offs and testing and interrogating ideas that take us beyond immediate crises.

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