

Nine major challenges facing health and care in England

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About UK 2040 Options

UK 2040 Options is a policy project led by Nesta that seeks to address the defining issues facing the country, from tax and economic growth to health and education. It draws on a range of experts to assess the policy landscape, explore some of the most fertile areas in more depth, test and interrogate ideas and bring fresh angles and insights to the choices that policymakers will need to confront, make and implement. options2040.co.uk

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About the Health Foundation

We are an independent charitable organisation working to build a healthier UK.

The logo for Nesta, consisting of the word "nesta" in a bold, blue, lowercase sans-serif font.

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Key points

- As we head towards the next general election, the state of the health service is one of the public's top concerns. The nation's health is fraying, more people are living with major illness and unfair differences in health between richer and poorer areas are widening.
- Nesta's UK 2040 Options project is looking at the defining issues facing the country ahead of the UK general election. In this long read, we highlight nine trends that represent some of the major challenges facing a new government on health and care in England – from changing health needs to the services available to meet them.
- The trends we outline paint a gloomy picture. But how they play out in future is not inevitable – and progress is possible with concerted policy action and investment. The next stage of work will set out policy options to address these challenges.

Introduction

Whoever is in government after the next general election will inherit a health and care system in crisis. The NHS is under extreme strain and many people are going without the care they need. In July 2023, the waiting list for routine hospital treatment in England had grown to nearly 7.7 million – an all-time high – with almost 390,000 people waiting more than a year.¹ Grim data on access to hospital care reflect pressures right across the system – in general practice, community services, mental health, social care: everywhere. These pressures are causing unnecessary pain and suffering for people and their families, as well as severe strain on staff. Public satisfaction with the health service is at an all-time low.²

But the NHS was not set up to go it alone. Good health depends on a broader set of factors beyond health care, like income, employment, housing, and the range of public services on offer. Yet too many of these building blocks of health have deteriorated after a decade of austerity and the COVID-19 pandemic – particularly for people living in the most deprived areas. Improvements in life expectancy in the UK have stalled,³ unfair differences in health between richer and poorer areas are wide⁴ and many people are out of work with ill health.⁵

The next UK government will face difficult choices on health and social care. Short-term pressures on the NHS require urgent attention, but so do longer term challenges facing the nation's health, which – in turn – will shape future demands on the health service and the resources available to meet them. Understanding the range of challenges facing health and care in the future is essential to identify the action needed by policymakers to address them.

We highlight nine trends that represent some of the major challenges facing any new government on health and care – focusing primarily on the NHS, social care and public health services in England. We then draw together some of the implications for policymakers. We produced this work for Nesta's UK 2040 Options project, which is looking at the defining issues facing the country ahead of the next general election.⁶ Other briefings are being produced on related policy challenges – for instance, by the Institute for Fiscal Studies on tax and public finances.⁷ The next stage of work will set out policy options to address these challenges, including our priorities for a new government on health and care.

1. Life expectancy is stalling and health inequalities are widening

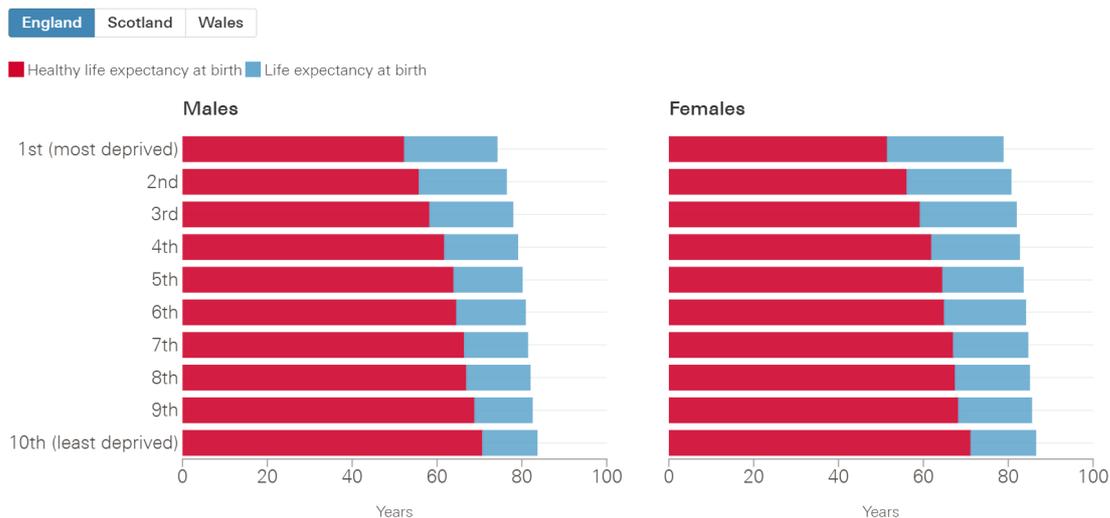
After a century of increases, the decade prior to the COVID-19 pandemic saw improvements in life expectancy among the UK population stall.⁸ For some, these improvements went into reverse: between 2010–12 and 2016–18, life expectancy among women living in the most deprived 10% of areas of England fell, with the largest decreases in the North East.⁹

Many countries experienced a similar trend, but the scale of the UK’s slowdown marks it out from other comparable countries.¹⁰ In 2000, the UK ranked 21st of 38 countries for female life expectancy at birth. By 2019, it had fallen to 26th place. Healthy life expectancy – the number of years that someone can expect to live in good health (not just how long they live) – has stagnated too. Recent analysis suggests that if trends in the decade leading up to the COVID-19 pandemic continue, it would take nearly two centuries (192 years) to reach the current government’s target to improve healthy life expectancy by 5 years (for men).¹¹

There are substantial inequalities in life expectancy. People living in more deprived areas of the UK tend to die earlier than people living in the least deprived areas, and spend a greater proportion of their lives in poor health.^{12,13} There is currently a gap of almost 20 years in how long a woman can expect to live in good health depending on whether she lives in the most or least deprived areas of England (Figure 1 and Section 2).¹⁴ These inequalities have persisted and increased over time (Figure 2).^{15,16} COVID-19 led to a sharp fall in life expectancy across the population – the biggest fall in England since World War II – but the impact of the pandemic was unequal and exacerbated existing inequalities further.^{16,17}

Figure 1: Life expectancy and healthy life expectancy among men and women by deprivation decile, England, 2017–19

Life expectancy & healthy life expectancy at birth by deprivation decile: Great Britain, 2017–19

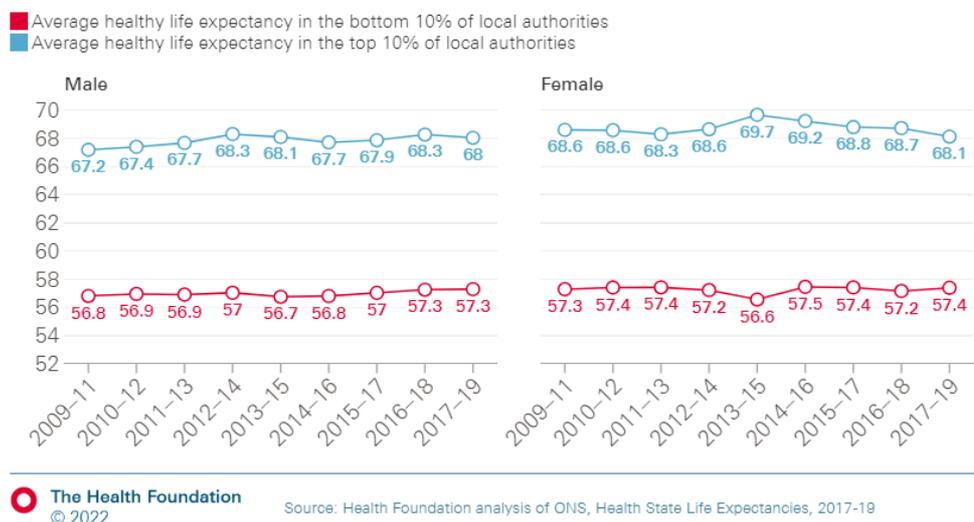


Source: <https://www.health.org.uk/evidence-hub/health-inequalities/life-expectancy-and-healthy-life-expectancy-at-birth-by-deprivation>

Figure 2: Gap in health life expectancy between 10% most and least healthy upper tier local authorities (UK), 2009–11 to 2017–19

The gap in healthy life expectancy between the most and least healthy 10% of local authorities has remained over the past decade

Top and bottom 10% of upper tier local authorities by health state life expectancy: UK, 2009–11 to 2017–19



Source: <https://www.health.org.uk/news-and-comment/charts-and-infographics/healthy-life-expectancy-target-the-scale-of-the-challenge>

The health of the population is shaped by a combination of social and economic factors, such as income, employment, education, housing and transport.^{18,19} These factors combine to shape the circumstances of people’s daily lives – for instance, their access to money to pay rent for housing and the conditions in the local neighbourhood in which they live. Yet these building blocks of good health are unevenly distributed across the population – and real-terms cuts in spending on public services over the decade going into the pandemic (2009/10 to 2019/20) mean some of these building blocks are missing for too many people.^{20,21}

The number of households in social rented homes experiencing affordability problems in the past 5 years, for example, has increased at a faster rate than in the previous two decades.²² Rates of in-work poverty in the UK have increased over the past two decades too, with almost 60% of people in poverty living in a household where someone works.²³ And the total number of households in temporary accommodation in England has risen by 95% since 2011 to almost 95,000.²⁴ More than three-fifths of these households had children. The sharp increase in the cost of living since 2021 will have brought increased stress and anxiety, and left many unable to afford the essentials needed to maintain their health.^{25,26} These pressures also impact on staff working in the NHS and social care.

2. Key risk factors are driving a significant and unequal burden of preventable ill health and premature death

Smoking, poor diet, physical inactivity and harmful alcohol use are the leading risk factors of preventable ill health and mortality in the UK.²⁷ All of these risk factors are socially patterned and have multiple causes, including structural social and economic conditions.²⁸ For example, people’s ability to adopt healthy behaviours is strongly shaped by the resources they have to buy food, the kind of work they do, the shops in their local communities and whether there are safe and accessible spaces to play and exercise.²⁹ Commercial influences matter too – for instance, in shaping the expense and availability of unhealthy food, alcohol, and tobacco, and how they are advertised and promoted.³⁰ Exposure to these risk factors can be influenced through national policy, like changes in prices and regulation. And the costs of this preventable burden of ill-health are substantial to individuals and society: the annual cost of obesity in the UK, for instance, has been estimated to be as much as £58bn, with major impacts on workforce productivity as well as demands on NHS and other public services.³¹

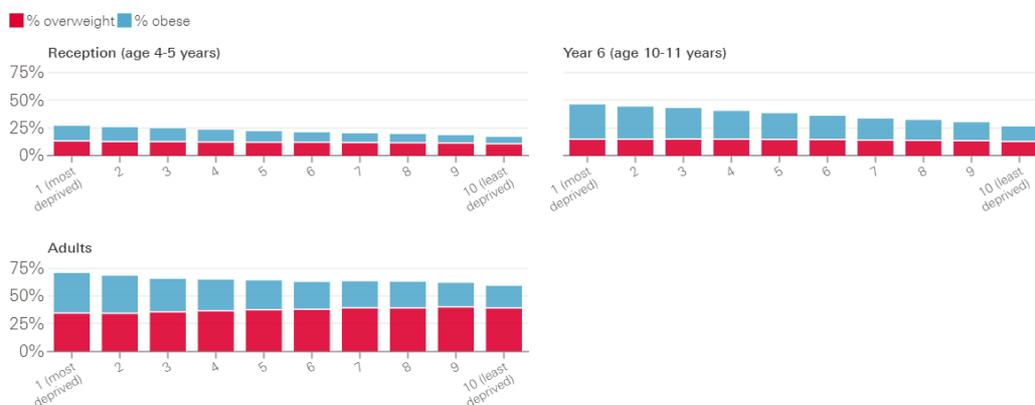
Trends for some of these risk factors are going in the wrong direction.³² Rates of childhood obesity in England have risen sharply in recent years (though have fallen back slightly in latest figures), smoking rates remain high among people working in routine and manual jobs and people with poor mental health, alcohol-related deaths are increasing, and physical activity levels are lower than in the past.³³

There are also significant – and in some cases widening – inequalities in exposure to these risk factors. This is particularly apparent for childhood obesity rates, which are highest and growing fastest in children from the most deprived areas (Figure 3). More than twice as many children from the poorest areas in England were obese in 2021/22 compared with those in more affluent areas. The prevalence of obesity in children in Year 6 increased from 24.6% to 31.3% among those living in the most deprived areas between 2013/14 and 2021/22, compared with an increase from 11.7% to 13.5% in the least deprived.³⁴

Figure 3: Prevalence of overweight and obesity in adults and children in 2021/22 by 2019 IMD

Childhood and adult obesity is higher in more deprived areas

Prevalence of overweight and obesity in adults and children in Reception and Year 6 in 2021/22 by 2019 Index of Multiple Deprivation (IMD) decile



Smoking prevalence in England has almost halved over the past three decades, from 29% in 1992 to 13% in 2022^{35,36,37,38} – supported by effective population-level policies including banning smoking in public places and introducing advertising restrictions, alongside providing support for people wanting to quit.³⁹ But inequalities persist. In 2019, 17% of adults in the most deprived areas in England smoked, compared with 9% in the least deprived. Among pregnant women, nearly 11% smoked at time of delivery in the most deprived areas, compared with 7% in the least deprived.⁴⁰ Smokers working in routine and manual occupations try to quit as often as more affluent individuals, but are less likely to succeed.⁴¹

3. People are living for longer but with major health conditions

A mix of factors affect the number of people living in poor health, including changes in the prevalence of leading risk factors for ill health, social and economic conditions, the size and age of the population and more. In England, the decade before the pandemic saw a more than 25% increase in the number of people living with major illness – conditions such as cancer and dementia or combinations of other illnesses.⁴² There has been a significant rise in the number of people living with multiple health conditions since the early 2000s.⁴³

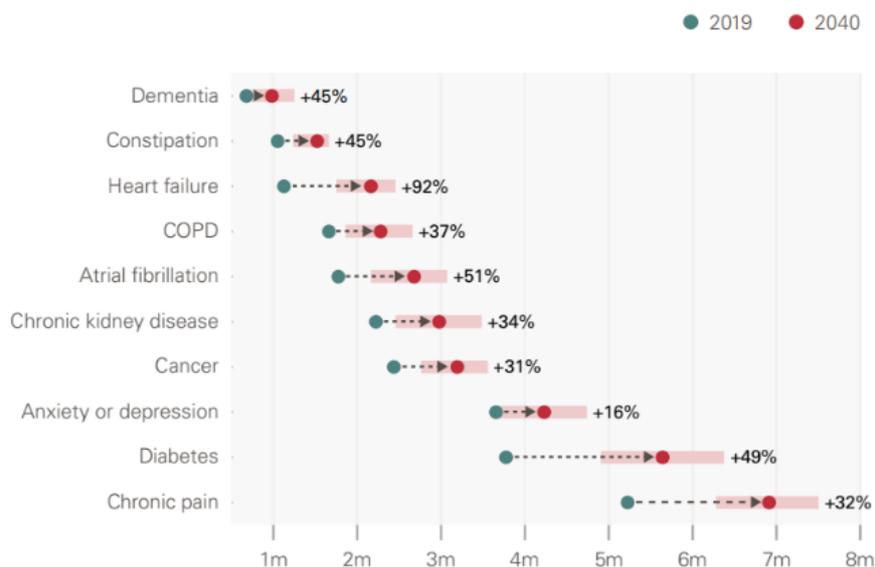
The burden of illness is not spread evenly. People living in more deprived areas are at greater risk of having multiple conditions and are more likely to develop them younger.⁴⁴ On average, a 60-year-old woman living in one of the poorest areas of England has diagnosed illness – such as chronic pain, diabetes, cardiovascular disease, or depression – equivalent to that of a 76-year-old woman living in one of the wealthiest parts of the country.⁴⁵

Recent analysis suggests these trends are likely to continue. By 2040, almost 1 in 5 of the adult population in England are projected to be living with major illness, an increase of 2.5 million people (37%) since 2019.⁴² Life expectancy is projected to rise by 1.4 years on average between 2019 and 2040, while the age at which people are expected to be living with major illness is projected to remain unchanged at 70 years old. Levels of multimorbidity are projected to rise for all age groups.

The growth in major illness will have substantial implications for the NHS and wider public services. Caring for more people with major illness will place additional demands on services across the NHS, but many of the conditions with the largest projected growth in absolute numbers, such as diabetes and chronic pain, tend to be managed in primary and community settings (Figure 4). Yet over the past 20 years, there has been a large shift in NHS activity and spending away from primary and community care and towards acute hospitals (Section 6). Changes in the population will also have implications for our ability to pay for growth in services. Our projections suggest that the ratio of the working-age population to the older population with major illness in England may reduce by nearly a third between 2019 to 2040.

Figure 4: Projected increase and case numbers for 10 health conditions with highest impact on health care use and mortality among adults aged 30 years and older, 2019 to 2040

Projected total number of diagnosed cases for the 10 conditions with the highest impact on health care use and mortality among those aged 30 years and older, including demographic changes, England, 2019 and projected for 2040



REAL Centre

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Source: Analysis of linked health care records and mortality data conducted by the REAL Centre and the University of Liverpool.

Note: Red shaded bars represent uncertainty intervals. COPD is chronic obstructive pulmonary disease.

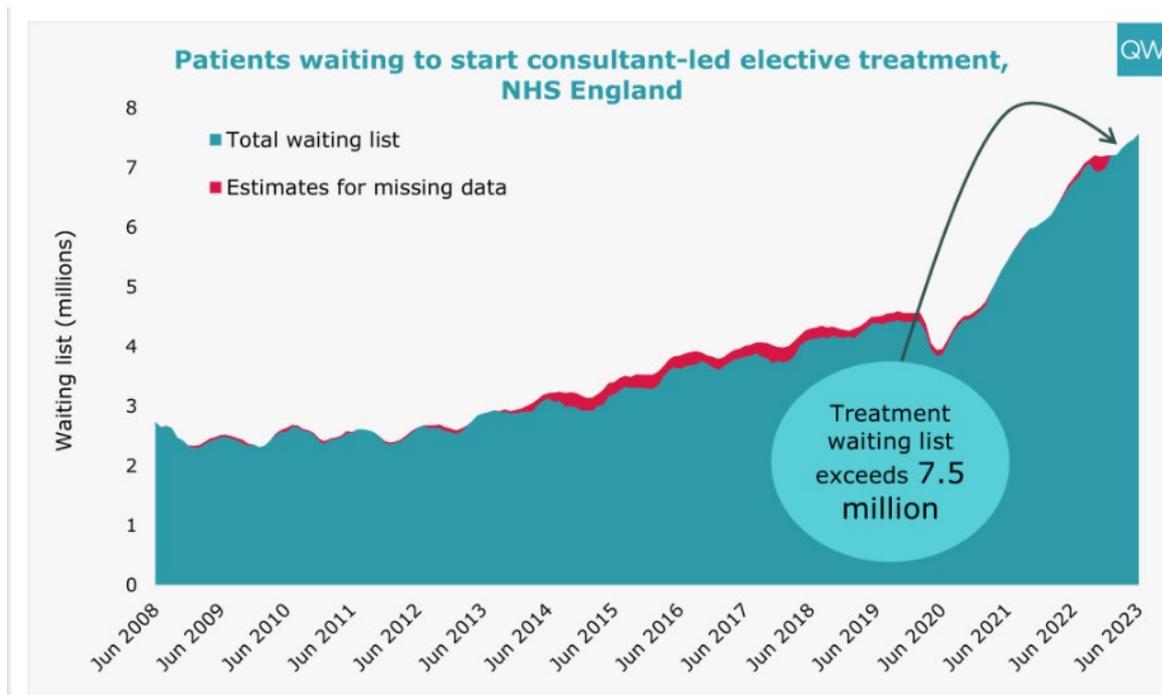
Source: <https://www.health.org.uk/publications/health-in-2040>

4. Unmet need for NHS and social care services is substantial and increasing

While health needs are set to increase, the NHS and social care are already struggling to deliver care and support to people who need it. COVID-19 caused widespread disruption to services, but access to care had already been worsening for a decade before the pandemic.

In July 2023, the waiting list for routine hospital treatment in England stood at 7.68 million – the highest since records began (Figure 5). Nearly 390,000 people had been waiting more than a year.⁴⁶ NHS waiting lists grew substantially in the decade prior to the pandemic, from 2.32 million in January 2010 to 4.57 million in January 2020. Targets for patient care are routinely being missed. The NHS constitutional standard that at least 92% of patients should wait no more than 18 weeks from referral to starting treatment has not been met nationally since 2016.⁴⁷ In cancer care, the 62-day waiting time target – that at least 85% of patients should start treatment within 62 days of an urgent GP referral – was last met in 2015.⁴⁸

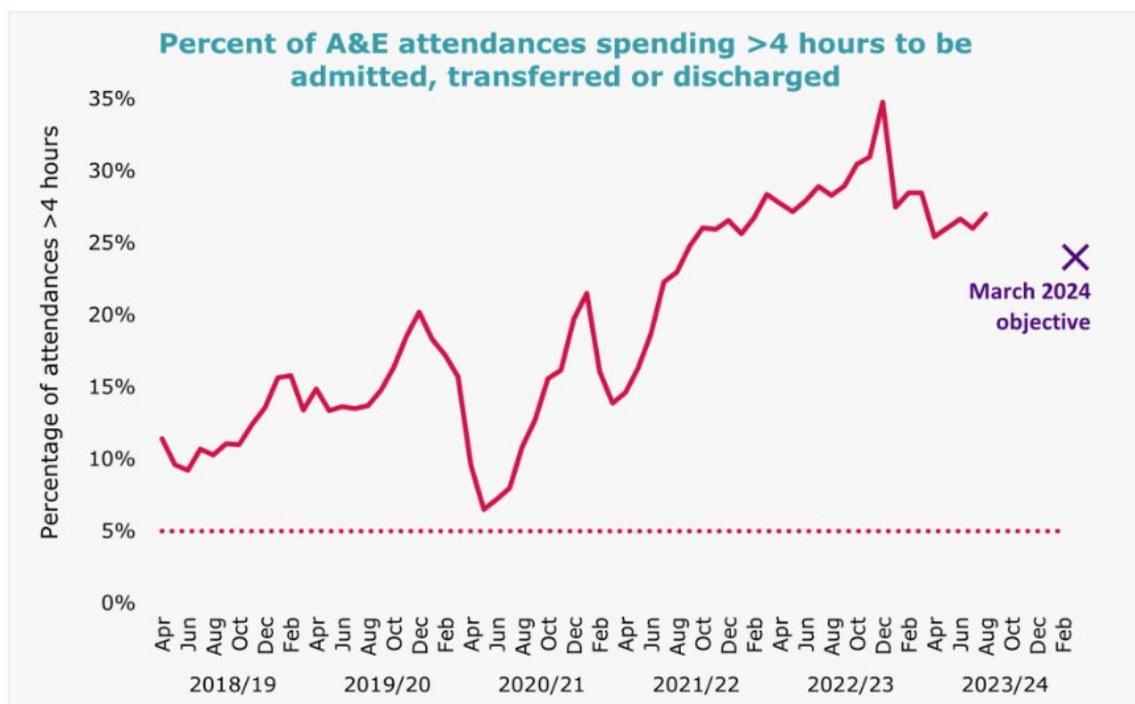
Figure 5: Patients waiting to start NHS elective treatment in England, June 2008 to June 2023



Source: <https://www.nuffieldtrust.org.uk/qualitywatch/nhs-performance-summary>

Emergency care is under intense pressure too. In 2022/23, only 70.8% of patients were admitted, discharged, or transferred within 4 hours of arrival in A&E (Figure 6) – well below the 95% target, which was last met in July 2015.⁴⁹ In the same year, 410,092 people waited more than 12 hours on trolleys in emergency departments for a hospital bed – more than double the total in the preceding 10 years combined (151,120 from 2012/13 to 2021/22).⁵⁰ Long delays in emergency departments are associated with increased risk of harm and deaths.⁵¹

Figure 6: Percentage of A&E attendances spending 4 hours plus to be admitted, transferred or discharged



Source: <https://www.nuffieldtrust.org.uk/qualitywatch/nhs-performance-summary>

Pressure on services outside hospital are harder to measure but also substantial. Large numbers of patients experiencing delayed discharges from hospital is a sign of limited capacity in social care and other community-based services to support people when they leave hospital. On an average day in July 2023, nearly 12,000 acute hospital beds – out of a total bed stock of around 100,000 in England – were occupied by patients who no longer had a medical need to be in acute care but could not be discharged home or elsewhere (though the majority of delays are likely to be attributable to the NHS, for instance due to difficulties arranging NHS rehabilitation support, rather than social care services).⁵² In June 2023, an estimated 992,189 people – children and adults – were waiting for community health services in England, such as community nursing and intermediate care.⁵³

GP appointment numbers are at near-record levels, but increasing numbers of people are finding it hard to get an appointment. People still rate the overall quality of primary care highly. But the 2023 GP patient survey found half of people (50.2%) reported difficulties getting through to their practice on the phone – the highest rate ever and up sharply from 31.7% in 2019.⁵⁴ 27.9% said they had avoided making an appointment when they needed one in the past 12 months because they found it too difficult. Waiting times for GP and hospital care are the biggest factor behind people’s dissatisfaction with the NHS (Section 8).

State-funded social care services are under extreme strain, struggling to provide care to people who need it. The number of requests to local authorities in England for social care support rose steadily between 2015 and 2021, yet the number of people accessing publicly funded long-term care fell.⁵⁵ Compared with other OECD countries, the UK has a high level of informal care provided by families and friends,⁵⁶ and support for them is limited.^{57,58}

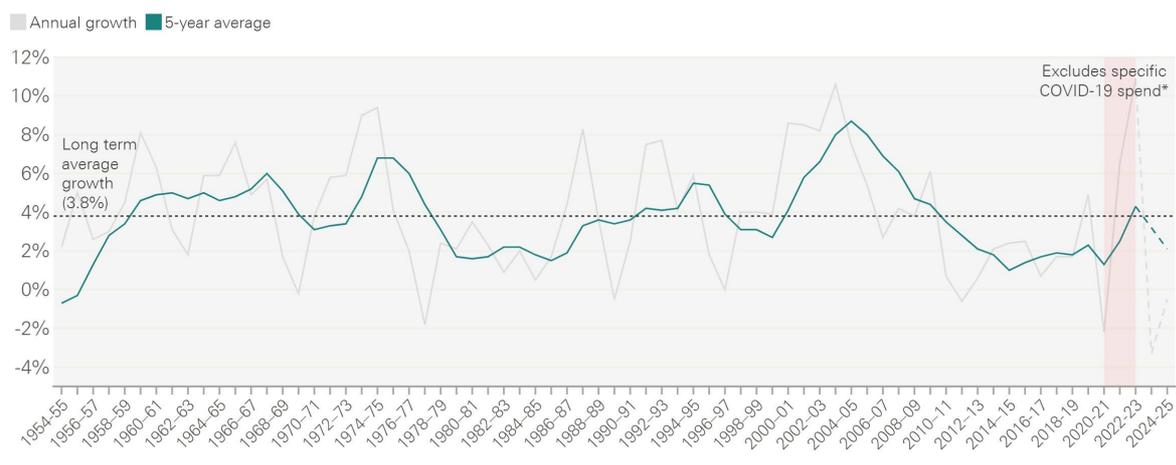
5. Long-run trends in health and care spending show a decade of underinvestment

A decade of underfunding going into the pandemic has constrained what health and care services can provide. Total government spending on health in England grew by only 2% a year in real terms over the decade before the pandemic – well below the long-run average of 3.8% (Figure 7).⁵⁹ Spending jumped up sharply during the pandemic (with annual growth of 5.7% between 2019/20 and 2022/23), when the NHS had to deal with the biggest shock in its history, with much of the extra funding going towards additional staff (see Section 7). Health spending is planned to increase by 0.1% in real terms between 2023/24 and 2024/25 – and future spending plans for the NHS are uncertain. There is strong public support for additional NHS spending (80% of the public in our latest polling), including most people intending to vote Conservative (60%) and the vast majority of Labour voters (93%).⁶⁰

Figure 7: Average real-terms growth in total health spending by government

UK health care spending over time

Annual and 5-year average, real terms (1954/55-2024/25)



REAL Centre

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Source: PESA, public sector expenditure by function (health), 2023-24 and 2024-25 are based on planned DHSC TDEL funding • OBR (GDP deflator, 2022/23=100)

*Specific COVID-19 funding is excluded, which is estimated based on DHSC TDEL values for COVID-19 and non-COVID-19 for 2020/21 and 2021/22

Source: <https://www.health.org.uk/publications/long-reads/health-care-funding>

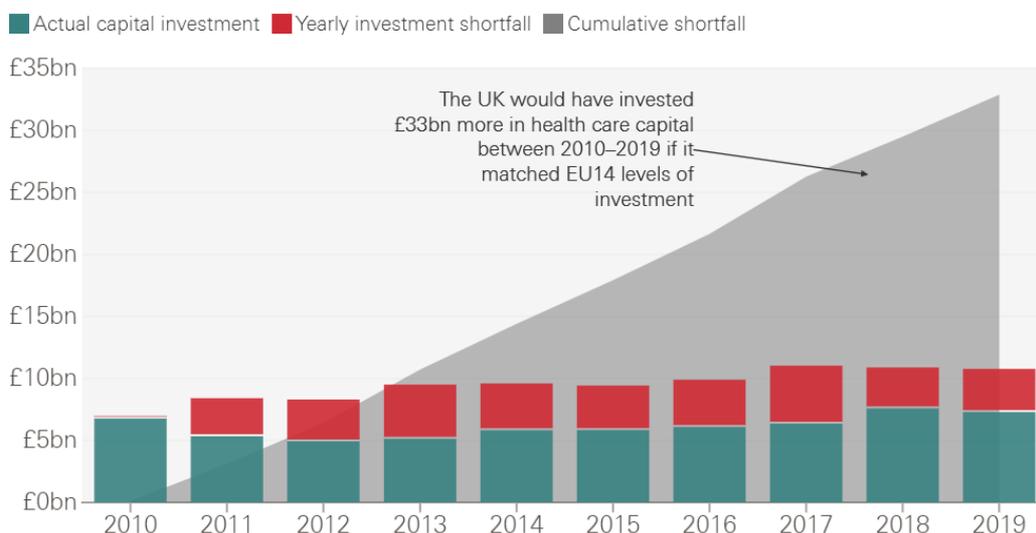
International comparisons of health care spending also point to weak investment in the decade before the pandemic. In 2019, UK health spending as a share of GDP was similar to other EU14 countries (such as France, Germany and Sweden).⁶¹ But average day-to-day health spending in the UK between 2010 and 2019 was £3,005 per person – 18% below the EU14 average of £3,655.⁶² This adds up: if UK health spending per person had matched the EU14 average, it would have spent around £40bn more a year between 2010 and 2019.

The UK also spent less on health care capital – long-term investment in things like buildings, equipment, data infrastructure and IT – than comparable countries.⁶³ If the UK had matched other EU14 countries' average capital investment (as a share of GDP), the UK would have invested £33bn more between 2010 and 2019 (around 55% higher than actual investment) (Figure 8).⁶⁴ Weak capital investment has a cumulative impact on the health system and its ability to operate effectively. Latest estimates suggest the NHS 'maintenance backlog' in

England – the cost of bringing deteriorating buildings or equipment back into suitable working condition – reached around £10.2bn in 2021/22.⁶⁵

Figure 8: Total UK health care capital investment and cumulative shortfall compared to other Eu14 countries, 2010–2019

Total UK health care capital investment and cumulative shortfall compared to other EU14 countries: 2010–2019



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

Spending on public health and social care has been more constrained than the NHS. Public health interventions are in general highly cost effective.^{66,67} Recent research estimated that each additional year of good health (measured by quality adjusted life years) achieved by public health interventions costs around £3,800 – three to four times lower than the cost per additional year of good health from NHS interventions (£13,500).⁶⁸ Yet the public health grant for local authorities in England – used to fund smoking cessation, drug and alcohol services, children's health services, and sexual health services – has been cut by 26% per person in real terms since 2015/16. Funding fell furthest in more deprived areas.^{69,70,71}

When the pandemic hit, government spending per person on adult social care in England was lower in real terms than in 2010.⁷² Recent projections suggest that simply meeting growing demand for social care over the next decade would require additional spending of around £8.3bn by 2032/33.⁷³ Doing this alongside improving access to care and providing additional funding to better meet the costs of care would come closer to £18.4bn by 2032/33.

6. The health system lacks capacity compared with many other countries

Weak investment has contributed to constrained capacity across the health system – holding back what services can deliver, but also leaving them vulnerable to shocks. Going into the pandemic, the NHS in England had lower numbers of hospital beds per person than most comparable countries (2 beds per 1,000 people) – similar levels to Canada and Sweden, but lower than countries like France (3 beds per 1,000) and Germany (6 beds per 1,000) – as well as lower levels of diagnostic equipment, like CT and MRI scanners (Figure 9).⁷⁴ The

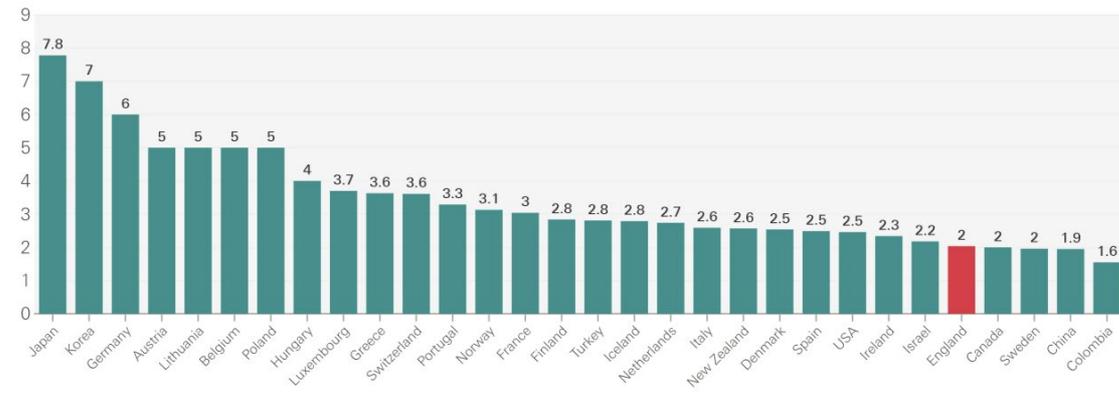
NHS also had much shorter lengths of stay in hospital and higher bed occupancy – running the system ‘hot’ (Figure 10).

Figure 9: Acute hospital beds per 1,000 of population in OECD countries, 2018

Acute hospital beds in OECD countries

Pre-pandemic, bed capacity in England was lower than many international comparators

Acute hospital beds per 1,000 of population (2018)



REAL Centre

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Source: OECD (2021), Hospital beds (indicator), doi: 10.1787/0191328e-en (Accessed on 21 October 2021). • Figure for England is estimated using NHS England data and ONS population. There is no data available for the UK.

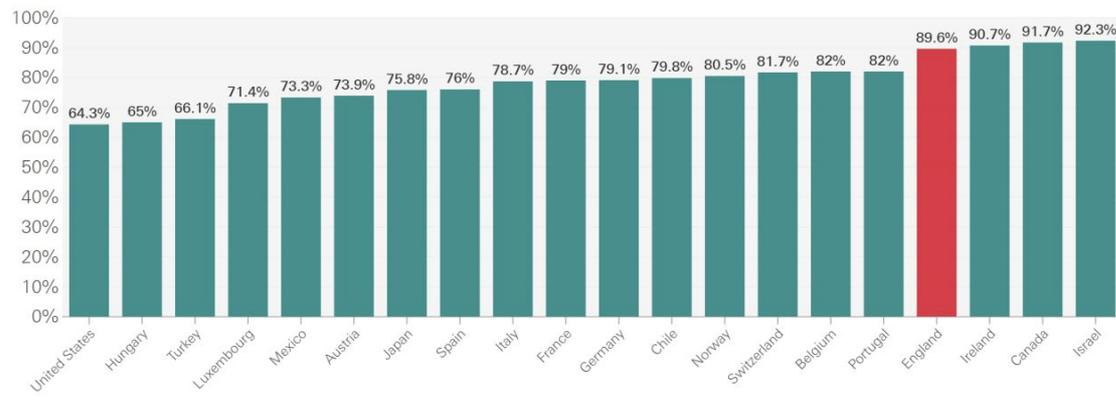
REAL Centre Projections: G&A hospital beds in England (2018–2030)

Source: <https://www.health.org.uk/publications/reports/how-many-beds-will-the-nhs-need-over-the-coming-decade>

Figure 10: Acute hospital bed occupancy rates in OECD countries, 2018

Acute bed occupancy level in England was also higher than most OECD countries

Bed occupancy rate (2018)



REAL Centre

The Health Foundation ©2021

Source: OECD dataset • Figure for England is estimated from NHS data for overnight and day only general and acute care beds.

REAL Centre Projections: G&A hospital beds in England (2018–2030)

Source: <https://www.health.org.uk/publications/reports/how-many-beds-will-the-nhs-need-over-the-coming-decade>

Too hot: bed occupancy rose to around 90% in the NHS before the pandemic,⁷⁵ beyond levels considered safe or efficient.⁷⁶ Increased pressure on beds since COVID-19 has likely led to unexpected rationing of care, as fewer people can be admitted to hospital.⁷⁷ A big

driver of this has been increases in length of stay in hospital – a reversal of pre-pandemic trends.

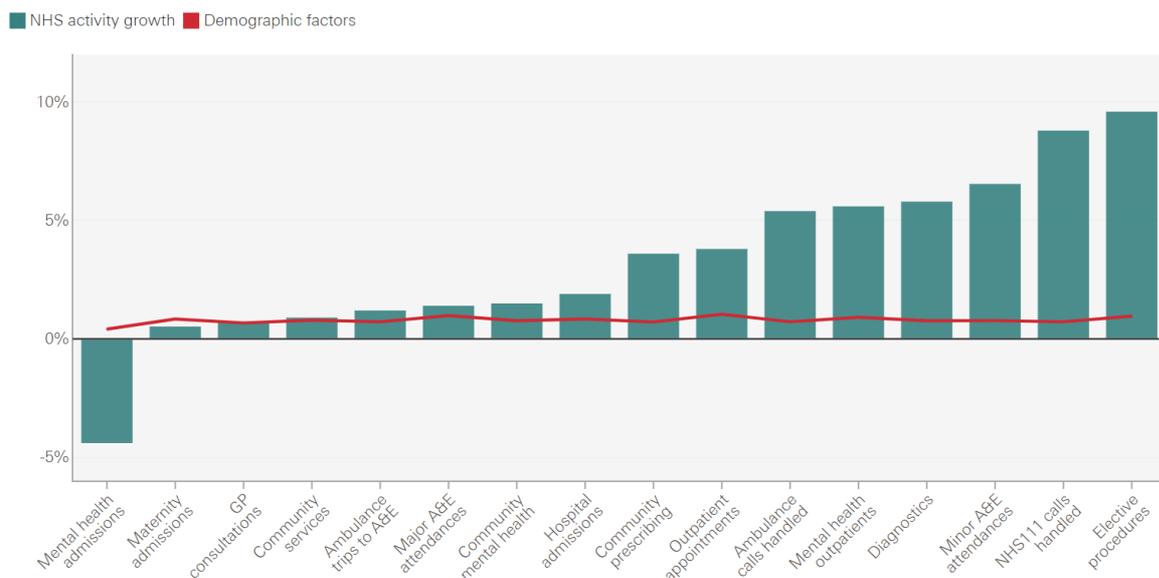
Constrained capacity has also contributed to a more recent ‘productivity puzzle’ in the NHS, where activity in NHS hospitals has not risen in line with increases in funding and staff since 2019 (see Sections 5 and 7). More staff can only do so much without the modern buildings, equipment, IT and beds to treat patients effectively – as well as the management and analytical capacity needed to improve the way the system works. The rate of growth in hospital managers in the NHS has been slower than for clinical staff – and the NHS appears to be severely undermanaged compared with other sectors and health systems.^{78,79,80}

As the population grows, ages and develops more complex health needs (Section 3), the capacity of the health and care system will need to expand to keep up. The number of hospital beds in England has roughly halved over the past 30 years, down to a mix of improvements in care, changes in policy and other factors. But recent projections suggest that simply maintaining 2018/19 standards of NHS care in England may require between 23,000 and 39,000 additional general and acute hospital beds by 2030/31, alongside big increases in staff (Section 7).⁸¹

Capacity also needs to grow in the right places. Despite longstanding calls to shift more NHS resources out of hospitals and into primary and community services, over the past 20 years there have been major shifts in the composition of NHS activity and spending in the opposite direction (Figure 11).⁸² Lack of capacity in social care and other community services is leading to unmet need and delays discharging patients (Section 4). There are also inequities in how resources are distributed. GP practices in more deprived areas of England are relatively underfunded and under-doctored compared with GP practices in richer areas.⁸³

Figure 11: Average annual growth in NHS activity by service compared to demographic pressure – 2000/01 to 2018/19 (years vary)

Annual growth by service: projected by demographics



Source: <https://www.health.org.uk/news-and-comment/charts-and-infographics/10-key-charts>

7. Staff shortages are persistent, with stress and burnout high

Staff shortages are widespread across the NHS and social care. Going into the pandemic, the NHS had fewer doctors and nurses per person than most comparable countries.^{84,85} Staff numbers have grown over recent years and there are more people working in the NHS now than in 2019. But this growth has not been even⁸⁶ and gaps remain. Staff vacancies in NHS trusts in England currently stand at around 125,000, an estimated vacancy rate of around 9%.⁸⁷ The NHS is short of around 4,200 GPs.⁸⁸ The number of appointments in general practice in England are near record levels, but the number of full-time equivalent, fully qualified permanent GPs has decreased since 2015.⁸⁹ In social care, staff vacancies are estimated at 152,000 – a rate of 10.6% and up substantially over the past decade.⁹⁰ Staffing levels affect quality and access to care.^{91,92}

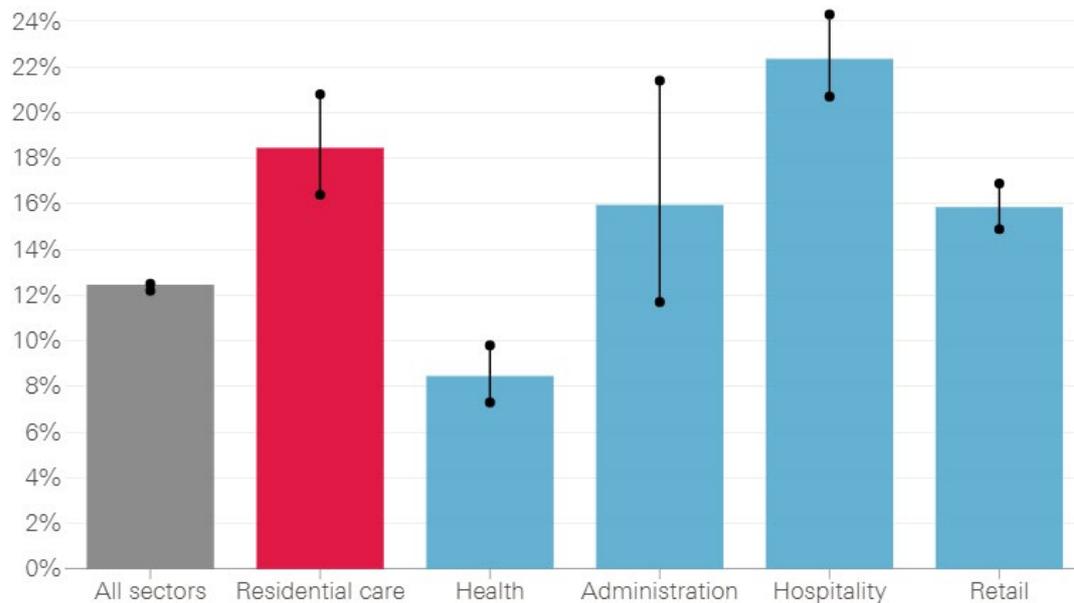
How far staff gaps grow over the next decade depends on policy action to address them. In summer 2023, national NHS bodies published a plan for meeting future staffing needs – including by training more doctors, nurses and other staff. Government committed £2.4bn funding for expanding training. But delivering the plan depends on sustained policy action and investment over many years – including in the buildings, equipment and IT needed for staff to work effectively (Section 6), as well as measures to help relieve pressure on staff

and keep them working in the NHS. Substantial investment is needed to boost staff numbers to the levels set out in the plan,⁹³ and there are questions about capacity to boost training.⁹⁴ No similar plan exists for adult social care, where staff turnover is high, terms and conditions are poor and care workers experience shocking levels of poverty and deprivation (Figure 12).^{95,96}

Figure 12: Percentage of workers in households in poverty by industry (UK), 2017–2020

Nearly 1 in 5 residential care workers are in poverty

% of workers in households in poverty after housing costs by industry: UK, 2017-20



 **The Health Foundation**
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Source: Health Foundation analysis of Households Below Average Income and Family Resources Survey, Department for Work and Pensions, 2020.

Source: <https://www.health.org.uk/publications/long-reads/the-cost-of-caring>

Meantime, patients and staff are feeling the strain. In the 2022 NHS staff survey, only around 26% of staff said that there were enough staff in their organisation to do their job properly.⁹⁷ Nearly half (around 45%) said they felt unwell because of work-related stress over the previous 12 months and around a third (34%) reported burnout. Staff gaps are one of the main reasons for falling public satisfaction with the NHS (Section 8), and boosting staff numbers and reducing staff workload are among the public’s top priorities for the NHS.⁹⁸

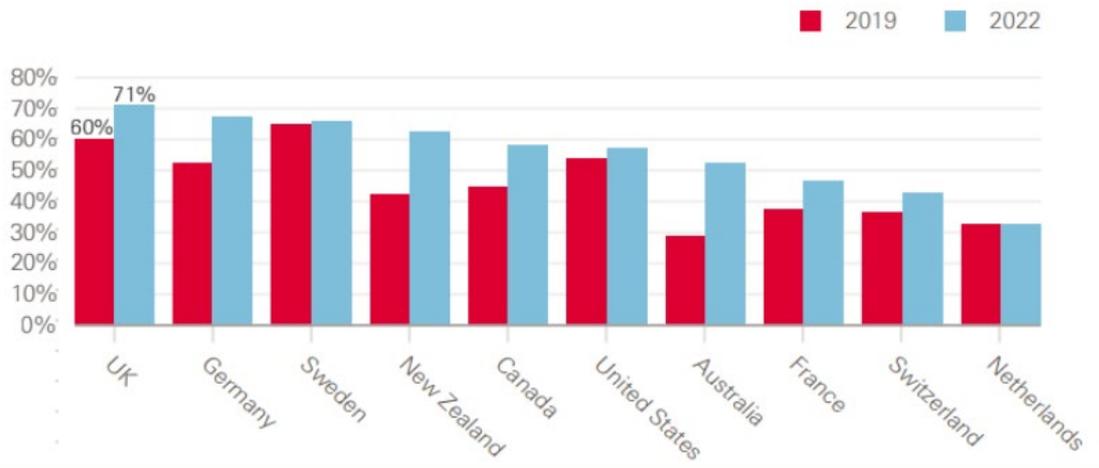
The experience of GPs in the UK compared with other countries is stark. A recent survey compared the working lives of GPs in 10 high-income countries including the UK, US, France, Germany and Australia. GPs in all countries were dealing with higher workloads than before the pandemic – and many have experienced greater stress and emotional distress.⁹⁹ But UK GPs reported higher levels of emotional distress and bigger rises in workload than GPs in other countries (Figure 13). Many are considering leaving the profession altogether.¹⁰⁰ UK GPs also reported among the highest levels of stress and

lowest job satisfaction. Just a decade earlier, UK GPs were among the most satisfied of any country.

Figure 13: Percentage of GPs describing their work as ‘very’ or ‘extremely’ stressful by country, 2019 vs. 2022

How stressful is your job?

The percentage of GPs responding ‘extremely stressful’ or ‘very stressful’, 2019 and 2022



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Source: Health Foundation analysis of the Commonwealth Fund's International Health Policy Survey of Primary Care Physicians in 10 Countries, 2019 and 2022. Note: In 2022, the UK is significantly different from all countries except Germany. See the appendix for 95% confidence intervals.

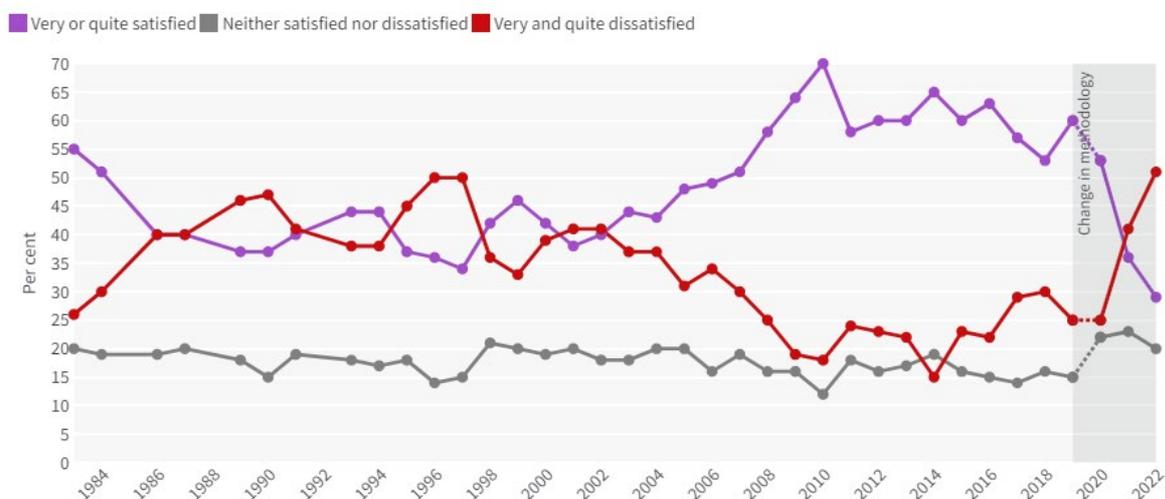
Source: <https://www.health.org.uk/publications/reports/stressed-and-overworked>

8. Public satisfaction with the NHS is at a record low, but support for its core principles remains rock solid

Public satisfaction with the NHS is at a 40-year low. The British Social Attitudes survey¹⁰¹ – a representative survey of adults in Britain conducted annually since 1983 – found that in 2022, only 29% of the public was ‘very’ or ‘quite satisfied’ with the NHS (Figure 14). Satisfaction has fallen sharply since the pandemic, with 60% of the public very or quite satisfied in 2019 – though satisfaction in 2019 was still well below its peak in 2010. The main reasons people gave for their dissatisfaction were waiting times for GP and hospital care (69%), staff shortages (55%) and a lack of public spending on the NHS (50%). Satisfaction fell across all ages, income groups and supporters of different political parties.

Figure 14: Public satisfaction with the NHS, 1983–2022

Question asked: ‘All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays?’



Source: The King's Fund and Nuffield Trust analysis of NatCen's BSA survey data
 2022 sample size = 3,362. This question was not asked in 1985, 1988 and 1992; 'don't know' and 'refusal' responses are not shown, in 2022 these response categories were selected by 0.16 per cent of respondents. Data has been carefully weighted to minimise differences due to the change in methodology between 2020 and previous years.

A Flourish chart

Source: <https://www.kingsfund.org.uk/publications/public-satisfaction-nhs-and-social-care-2022>

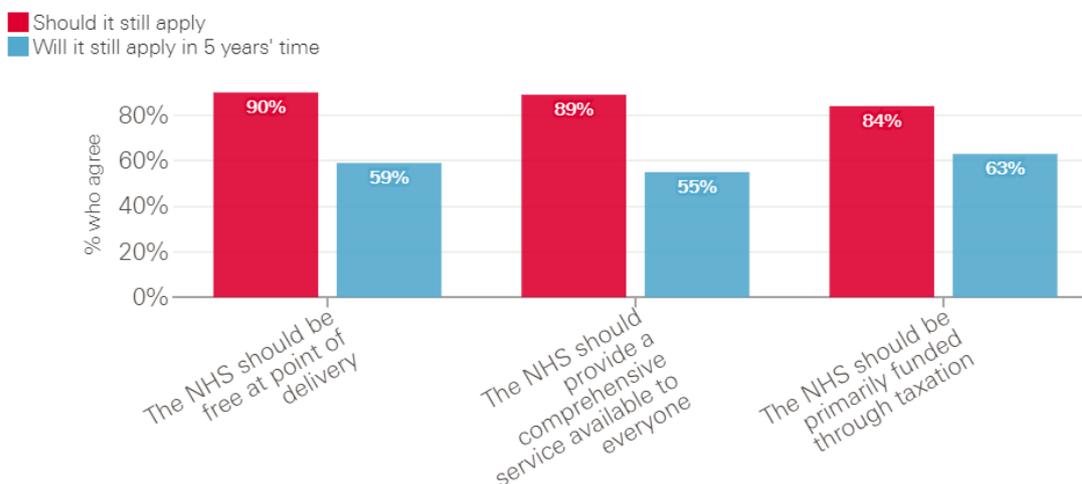
The public is pessimistic about how NHS services will fare in future. Recent polling found that 54% of people expect standards of NHS care to get worse in the coming year and only 11% expects standards to improve.¹⁰² There is also concern about the NHS's ability to meet future challenges. 77% of the public thinks the service is not prepared to meet the increasing health demands of an ageing population (just 17% said it was prepared).¹⁰³

Despite falling satisfaction with NHS services, the UK public continues to overwhelmingly support the core principles of the NHS. 90% of people think the NHS should be free at the point of delivery, 89% that the NHS should provide a comprehensive service available to everyone and 84% that the NHS should be primarily funded through taxation (Figure 15).¹⁰⁴ These principles receive majority support across the party-political spectrum. 72% of people see the NHS as 'crucial to British society' and think that 'we must do everything to maintain it'.¹⁰⁵ This includes strong support among the public for increasing NHS funding (Section 5).

Figure 15: Public support for founding principles of the NHS

Public support for the NHS's founding principles is high but there is concern over their longevity

When the NHS was set up in 1948, it was based on several core principles. For each principle, to what extent...



Source: All participants, Nov 2022 n=2,063 24–30 November 2022. All conducted online via KnowledgePanel UK.

Source: <https://www.health.org.uk/publications/long-reads/public-perceptions-of-the-nhs-a-winter-of-discontent>

Despite this, the public has real concerns about whether the NHS model will be maintained in the years ahead. When asked if the NHS would be generally free at the point of use in 10 years' time, half of respondents (51%) said they expect to pay for some services that are currently free at the point of use and 13% expected to pay for 'most' services.¹⁰⁶

9. The NHS is repeatedly reorganised, while social care is overlooked

The NHS in England has been regularly reorganised. In its first 30 years, the structure of the NHS was relatively stable. But over the past 30 years, the NHS has been on a treadmill of top-down reform and reorganisation. NHS commissioners, for instance – responsible for planning and purchasing local services – have existed in almost constant organisational flux since the NHS internal market was introduced in 1991.¹⁰⁷ The latest round of reforms led to the establishment of 42 integrated care systems in England¹⁰⁸ – area-based agencies responsible for managing NHS services and spending. Evidence suggests that top-down restructuring in the NHS has delivered little measurable benefit – and can cause harm.¹⁰⁹

Meantime, social care has been neglected by national policymakers. The adult social care system in England is a threadbare safety net, with state-funded support only available to people with the highest needs and lowest means. Many people go without the care they need – and some face catastrophic costs. The absence of state protection against care costs is a glaring gap in our welfare state.^{110,111} Successive governments have promised to reform the broken system. In 1997, Tony Blair told the nation that he did not want children to

grow up ‘in a country where the only way pensioners can get long-term care is by selling their home’. Boris Johnson promised to ‘fix the crisis in social care once and for all’ when he became Prime Minister in 2019. And a long line of white papers, independent commissions and even legislation on social care reform came in between. But reform has been repeatedly ditched or delayed – and people and their families continue to suffer unnecessarily.

Policy choices made by the next government will shape the future of the nation’s health

The rollcall of health and care challenges facing the next government is long and daunting. Health systems around the world are still reeling from the effects of COVID-19 – and will be for years to come. But the underlying causes of the current crisis are much longer term – including a decade of underinvestment in the NHS and wider public services, weak capacity, staff shortages, political neglect of adult social care and more. Growing numbers of people are struggling to get the care they need today and pressures on services are only set to increase as more people live longer with major illness over the coming decades. The health of the population is stalling and inequalities between rich and poor are widening.

Responding to these challenges is not just about greater investment, but it will not happen without it. Services across the public sector are creaking after a decade of austerity¹¹² and the outlook for economic growth that drives investment is weak.^{113,114} Policymakers face a choice: unless health spending grows over the long term in a way that reflects changing health needs, services will deteriorate, long waiting lists will be here to stay and the social contract underpinning the NHS may fray. But increasing spending on the NHS and other public services would likely require tax rises¹¹⁵ – and, even then, additional spending will take time and policy change to translate into better services. Government must also choose where to focus: for instance, how will it balance short-term objectives to increase access to NHS services with the longer term investment needed to improve social conditions shaping health?

Changes to how the health and care system works will be needed. Population ageing and the growing burden of disease mean longstanding policy objectives to strengthen disease prevention and deliver more coordinated services outside hospitals must become a reality. Past evidence shows this is easier said than done.^{116,117} But there are obvious places to start. For instance, successive governments have promised and then failed to reform England’s broken system of social care and support – leaving a gap in our welfare state.¹¹⁸ Stronger policy action is also needed to tackle the leading risk factors of preventable ill health and mortality, such as obesity. Population-level interventions – policies that impact everyone and do not rely on high levels of individual agency, such as a sugar and salt reformulation tax and expanding eligibility for free school meals – are most likely to be effective and equitable.^{119,120,121} Yet national policies implemented in England over the past decade have largely focused on individual behaviour instead.¹²² The next phase of Nesta’s 2040 Options project will look at these and other policy options to address the major challenges facing the nation’s health.

Debate about the future of NHS reform often focuses on the structure of the system. The NHS has been on an almost constant cycle of top-down reorganisations since the 1990s. And some media commentators and backbench MPs often point to the NHS’s funding model as a potential target for ‘radical’ reform – for instance, by introducing new user charges or switching to a different model for raising revenue. Evidence suggests these are the wrong places to look.^{123,124,125} The public have little appetite for them either. Instead, policymakers

should focus on how they can best support the NHS to test and expand new ways of delivering care to meet the changing health needs of the population – including harnessing developments in data and technology and strengthening primary and community services, as well as learning from the rapid service changes implemented during the pandemic.¹²⁶

The trends we outline paint a gloomy picture. But how they play out in future is not inevitable. The NHS faced long waiting lists in the 1990s but brought them down through concerted policy action and investment over more than a decade.^{127,128} Long-run falls in UK smoking rates since the 1970s illustrate the impact of population-level interventions to reduce major health risks.¹²⁹ And evidence on the impact of England's health inequalities strategy in the 2000s shows progress on reducing inequalities is possible with sustained investment in public services and a mix of social programmes.^{130,131} For better or worse, policy choices made by the next government will shape the future of the nation's health.

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