# The NHS at 77: a national treasure or a system in crisis?

## Speakers:

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## Discussants:

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## Chair:

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# Comparative performance of the UK health and care system

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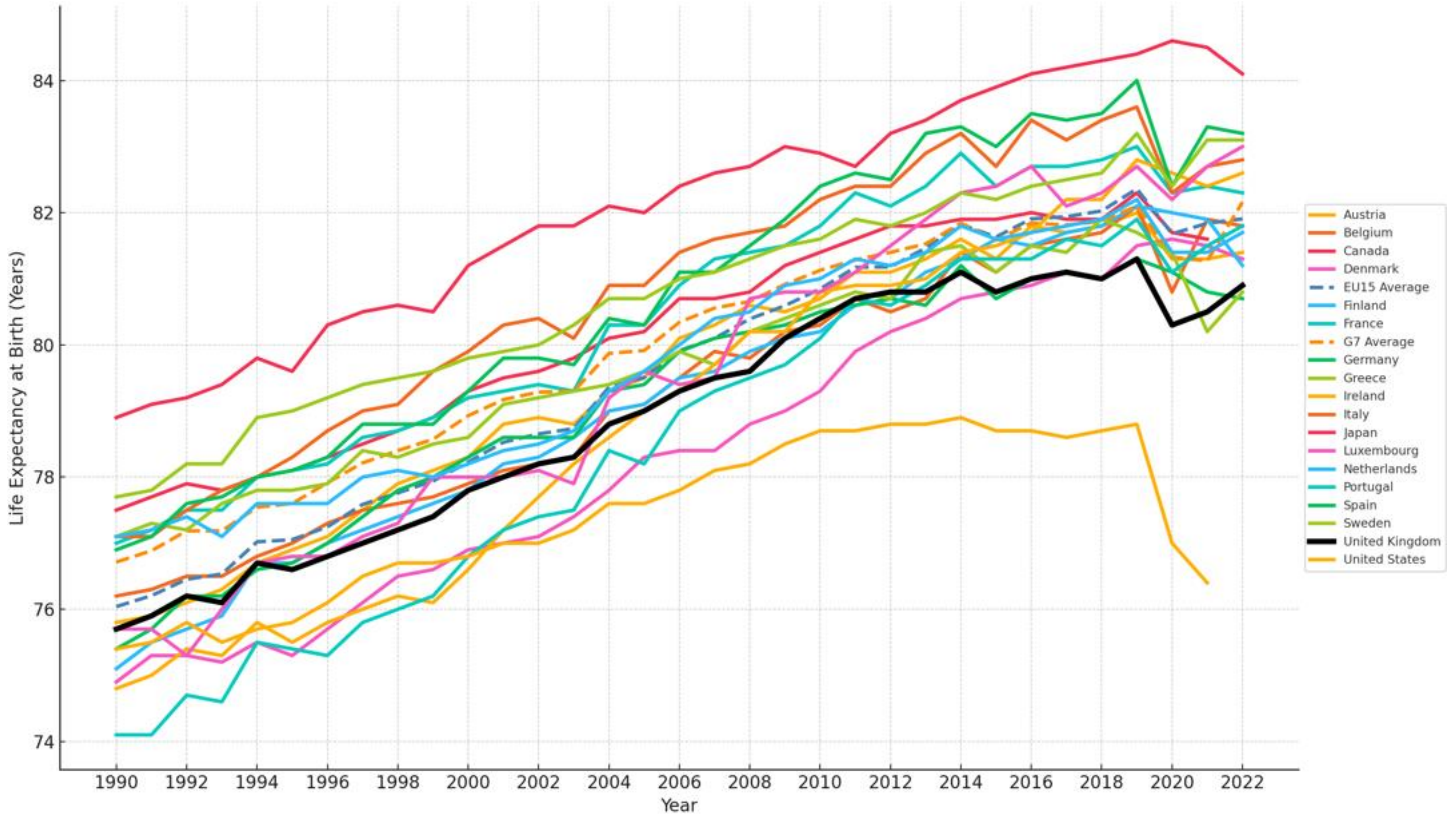
lse.ac.uk/health-policy

# Health and care in the UK

## Weaknesses

- Poorer health outcomes than many comparable high-income countries
- Widening health inequalities

**Trends in life expectancy at birth in the United Kingdom and comparable high-income countries**



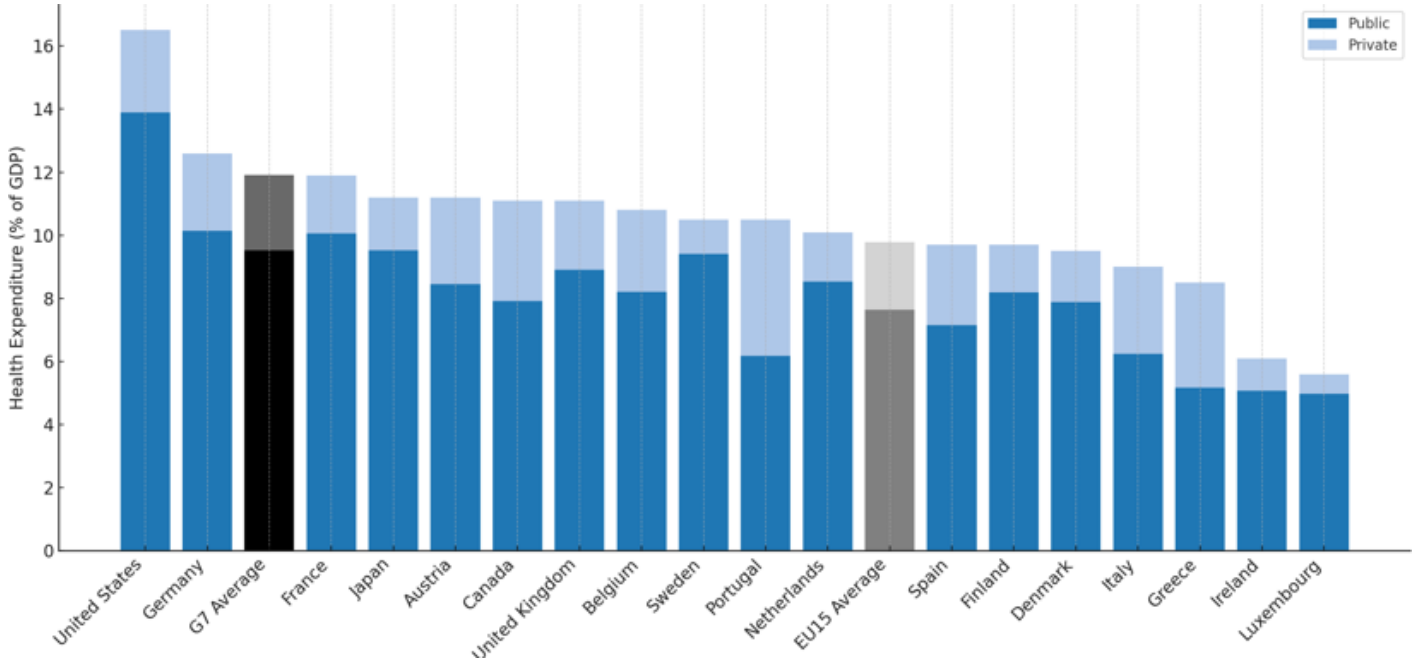

Source: OECD data

# Health and care in the UK

## Weaknesses

- Lower funding than many other G7 countries
- “Feast and famine” approach to funding settlements
- Reductions in social care funding

**Spending on health in G7 and EU15 countries, 2023 or latest year**



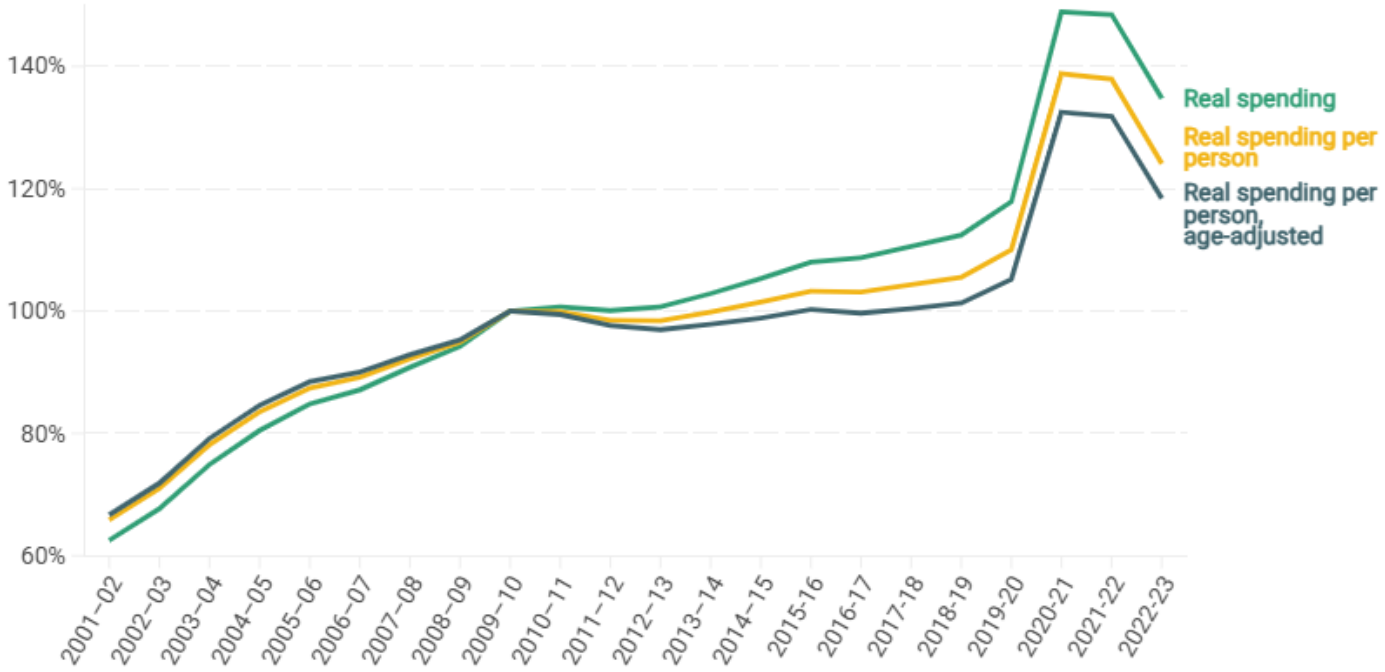

Source: OECD data

# Health and care in the UK

## Weaknesses (Funding)

- Prior to the COVID-19 pademic, total (real) health spending increased over, but when adjusted for demographic changes, spending remained relatively flat.

**UK health spending per person and age-adjusted per person**



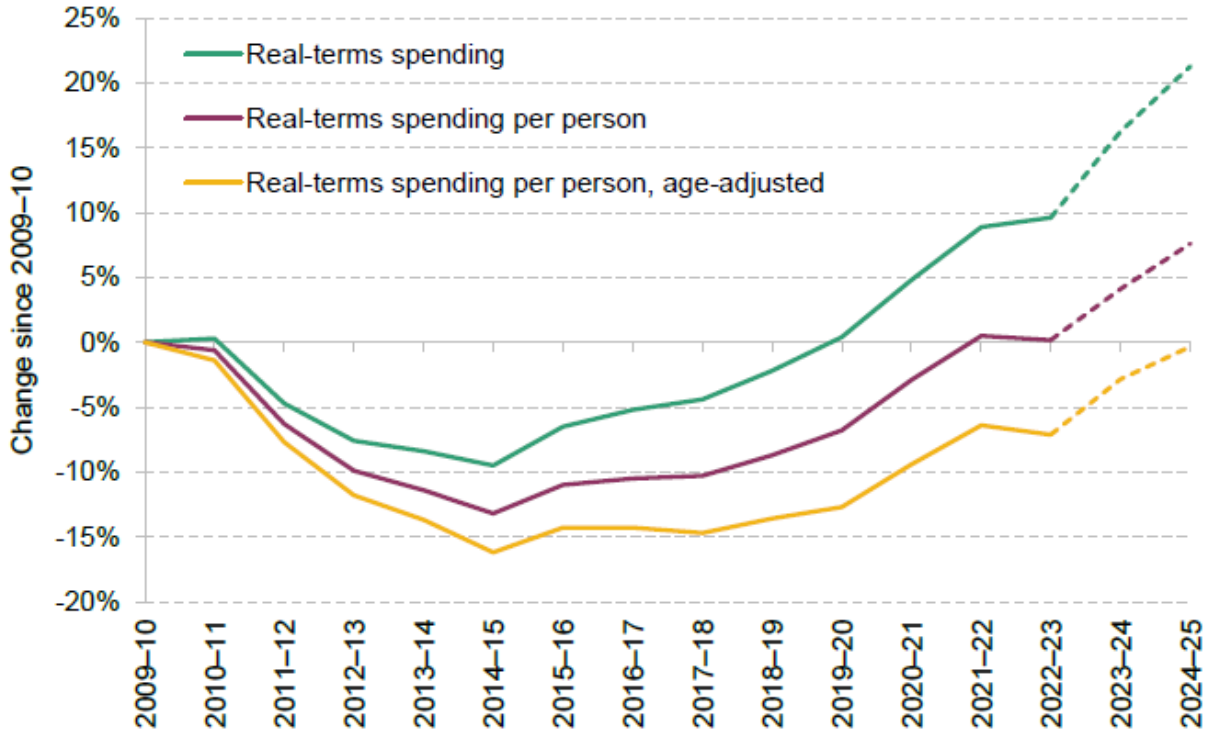

Source: IFS, 2024

# Health and care in the UK

## Weaknesses (Social care funding)

- While focusing on total (real) social care spending and adjusting for demographic changes, we see that spending is lower than 15 years ago.

**Percentage change in net current expenditure on adult social care services (age 18+) in England since 2009–10**



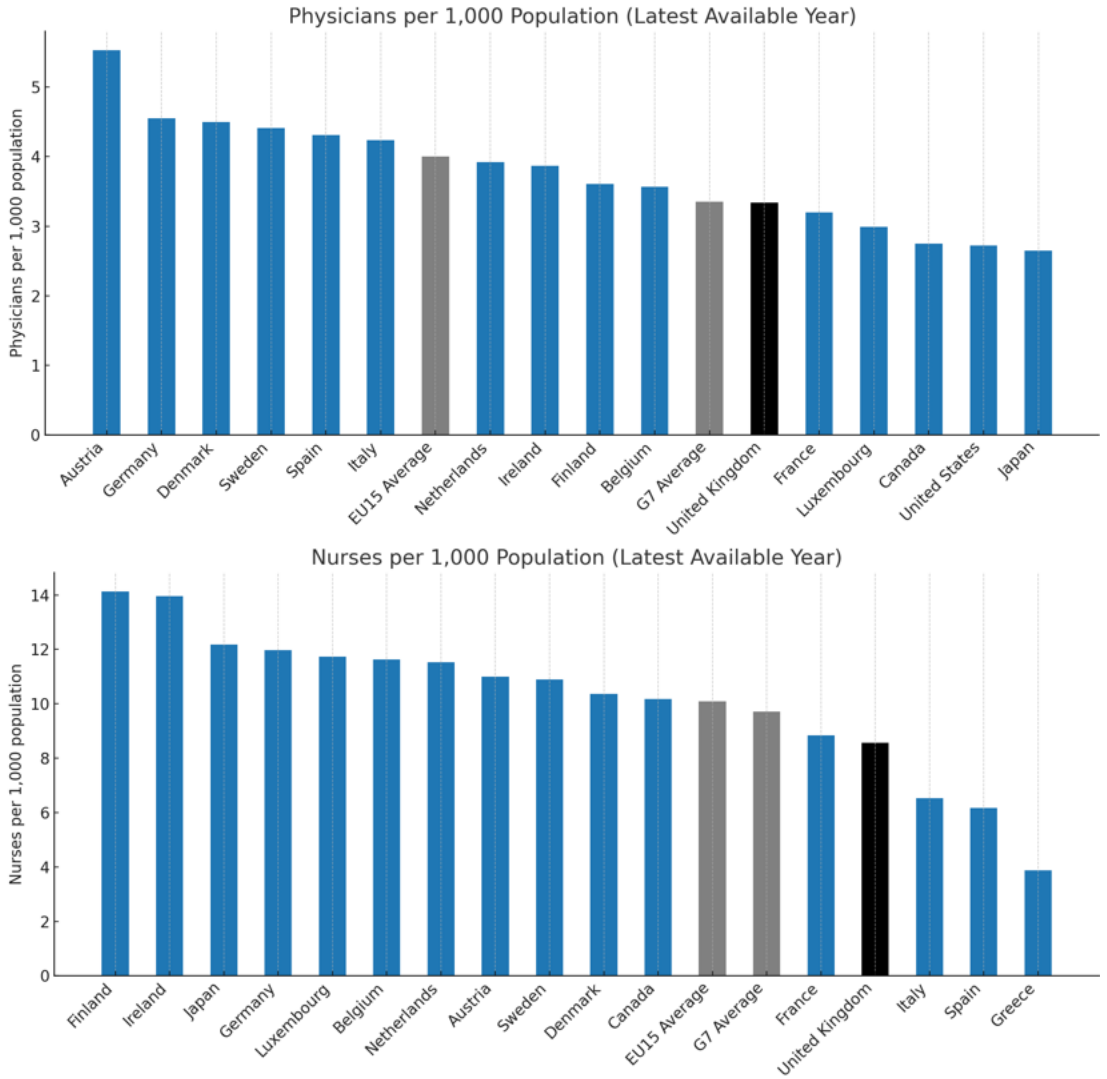

Source: IFS 2024

# Health and care in the UK

## Weaknesses

- Comparatively lower staffing levels (including doctors and nurses) than other comparable high-income countries
- Ineffective long-term workforce planning efforts

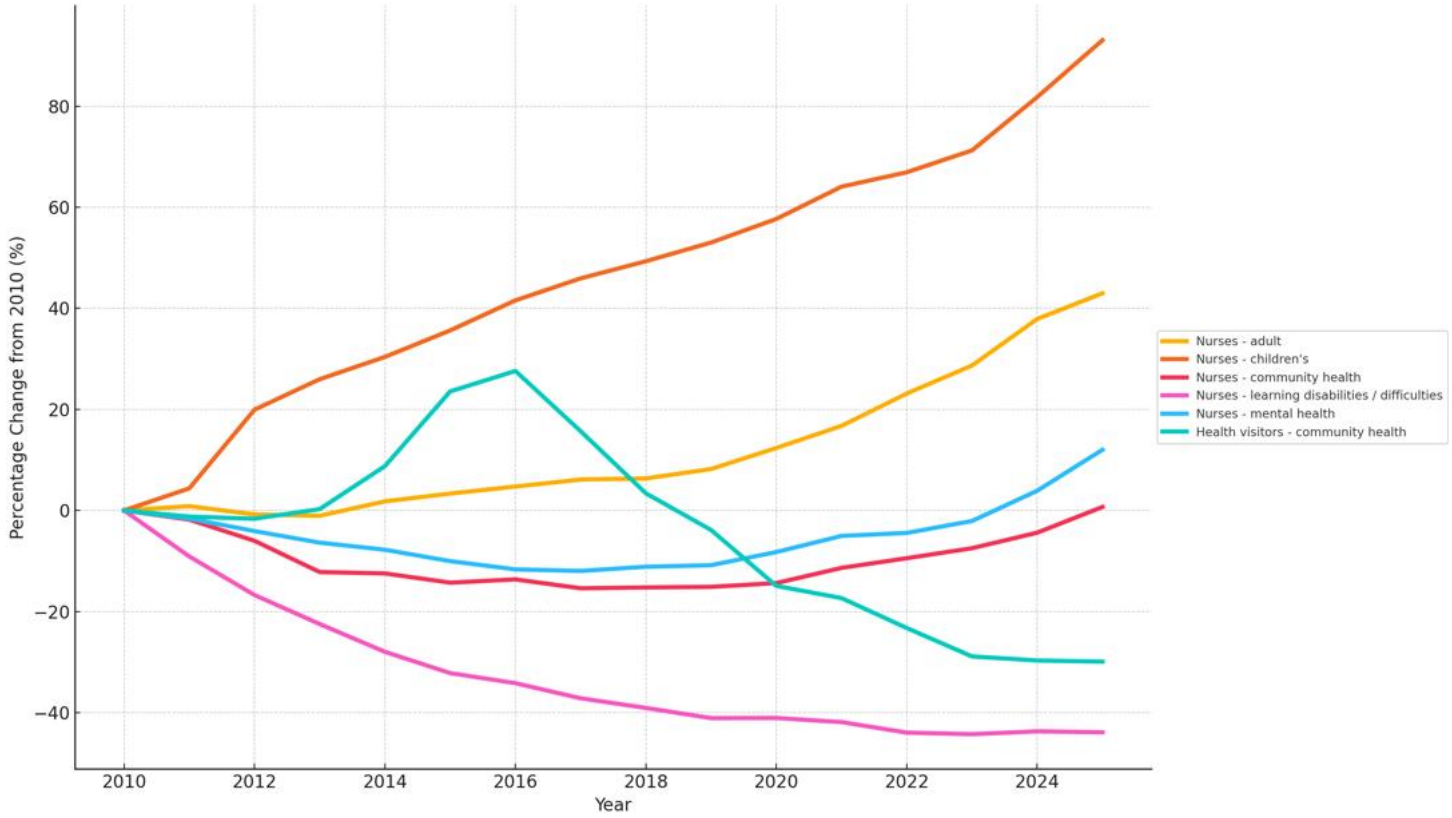
**Nurses, and physicians in the EU15 and G7 (2023 or latest year available)**




Source: OECD data

# Ensure capacity, roles and skills mix reflect changing population health and care needs

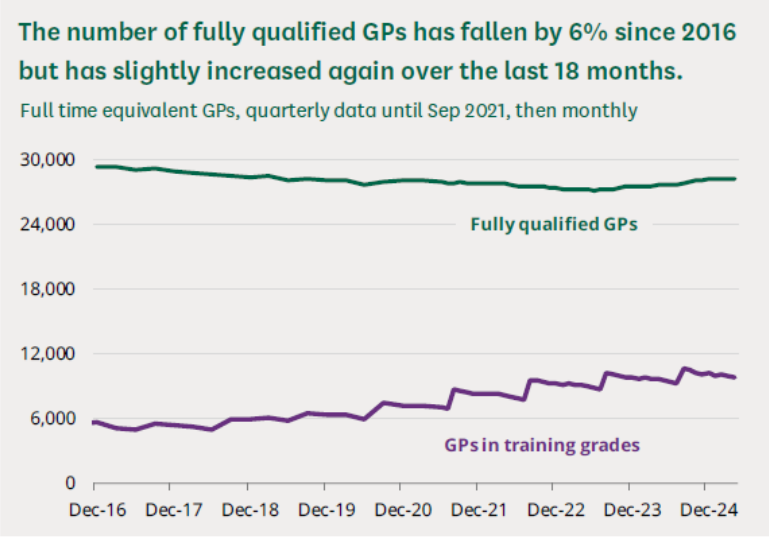
**Total percentage change in registered nursing numbers (FTE) in England between 2010 and 2025**




Source: NHS England

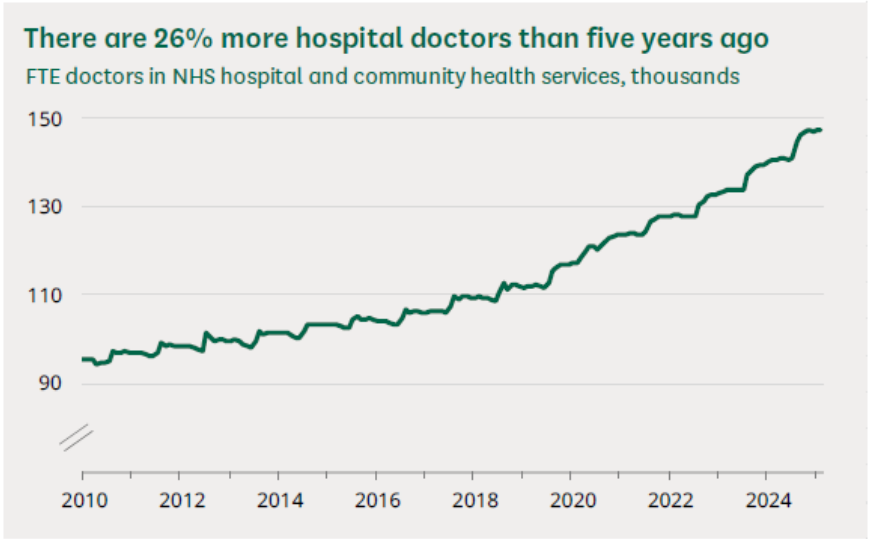
- Despite policy imperatives to shift care into the community and support growing demands for mental health care, any growth in the nursing workforce has been located in hospitals

# Ensure capacity, roles and skills mix reflect changing population health and care needs




Source: NHS Digital, General Practice Workforce, Bulletin Tables – April 2025, Table 1a

- Similarly when analysing trends in physician we again see growth concentrated in hospital consultants with GP numbers stagnating



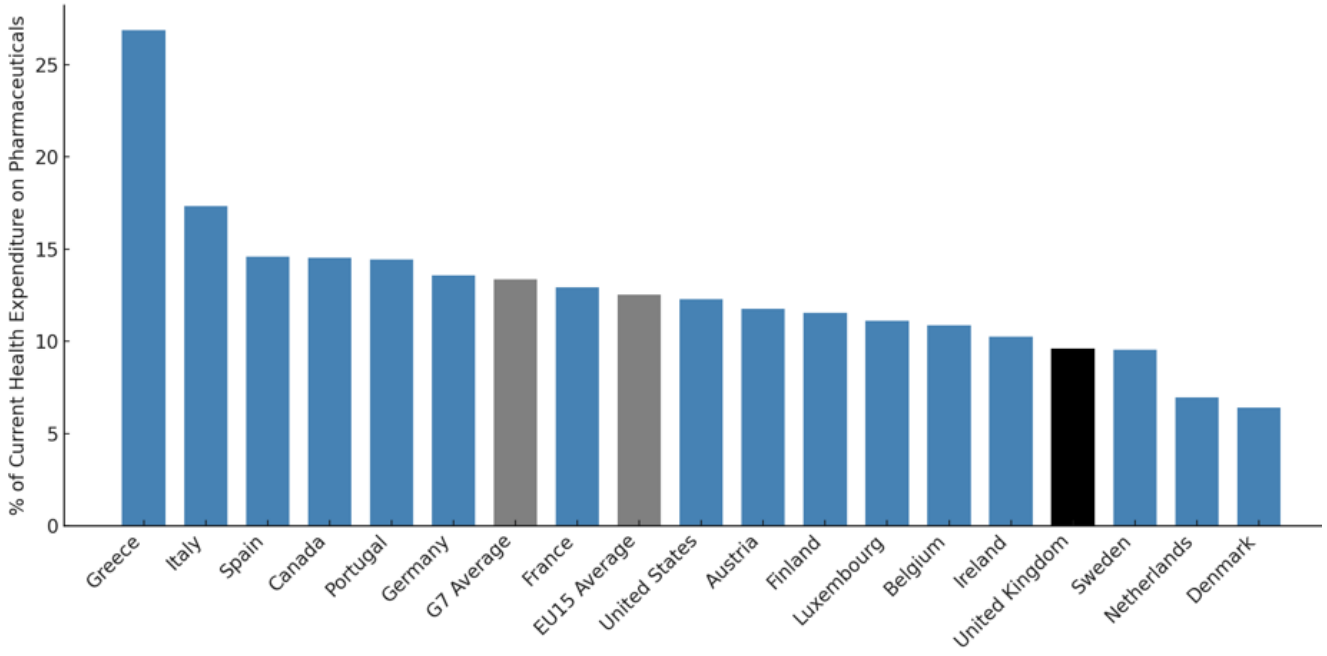

Source: NHS Digital, NHS Workforce Statistics - February 2025, England and Organisation data file

# Health and care in the UK

## Strengths

- Systematic and data-informed approach to resource allocation at the national level
- Robust and transparent approach to health technology assessment
- High generic prescribing, and competitive tendering of generics contribute to control of pharmaceutical spending

**Pharmaceutical spending as % of total health spending, 2022**



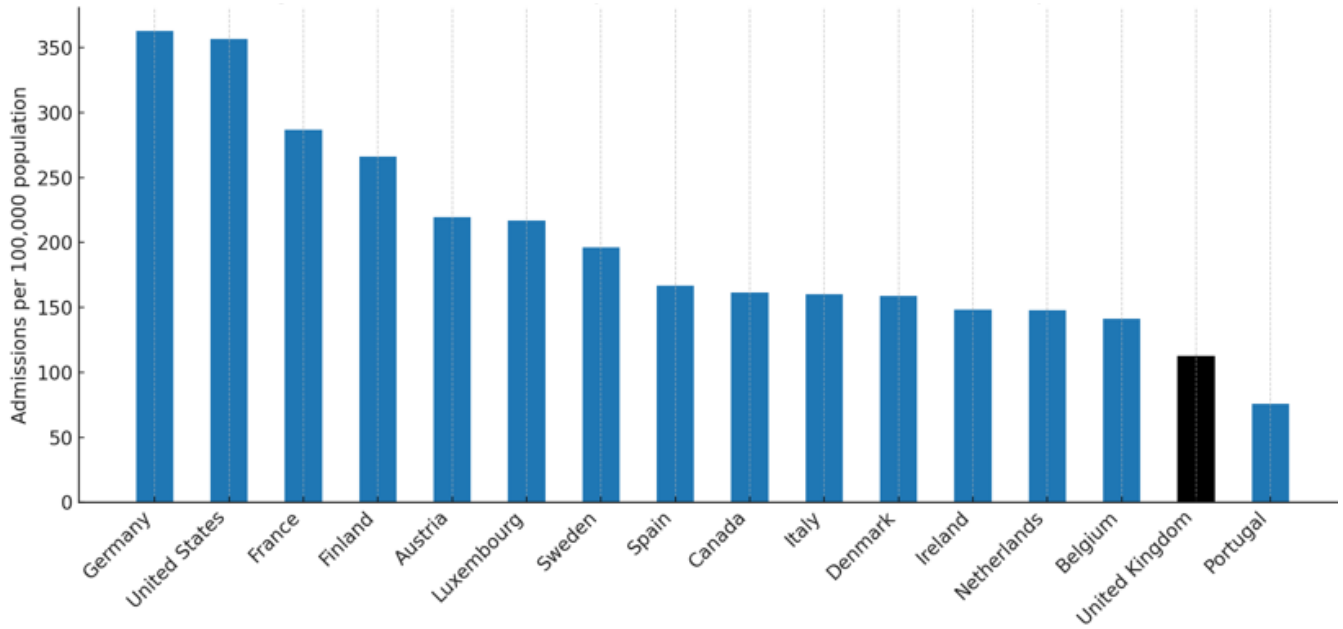

Source: OECD data

# Health and care in the UK

## Strengths

- Comparatively better performance in chronic disease outcomes than many other high-income countries

**Congestive Heart Failure Hospital Admissions for EU15/G7 countries, 2022 or latest available data**

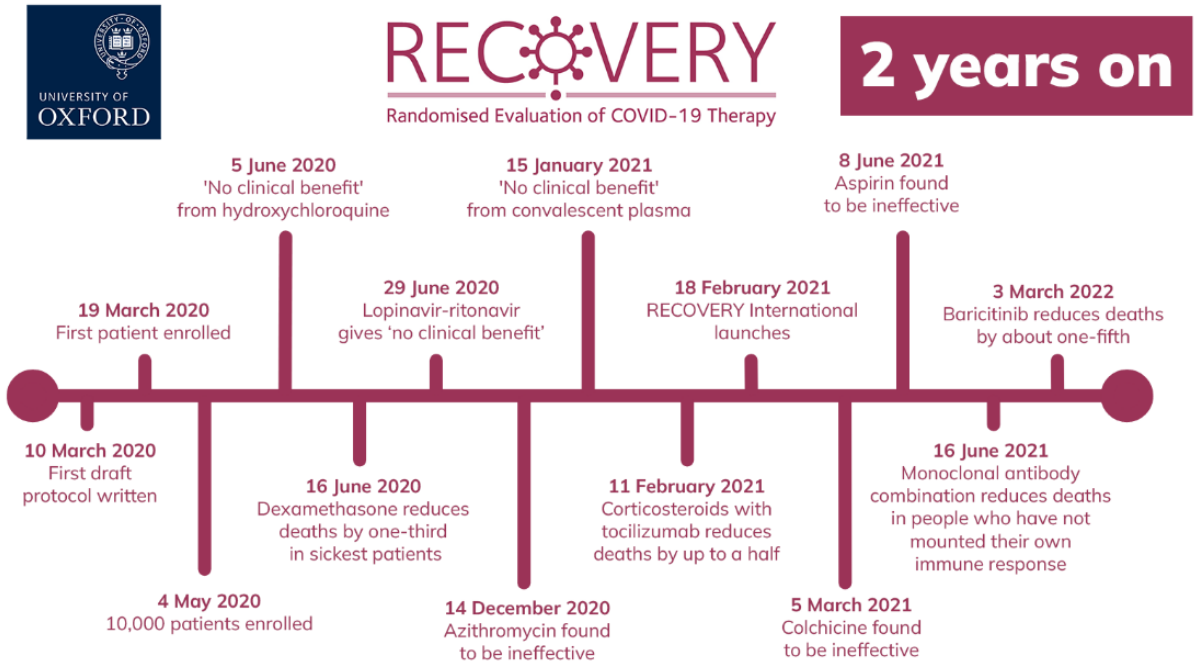



Source: OECD data

# Health and care in the UK

## Strengths

- Research and innovation infrastructure that contributes to delivery of world-leading clinical trails

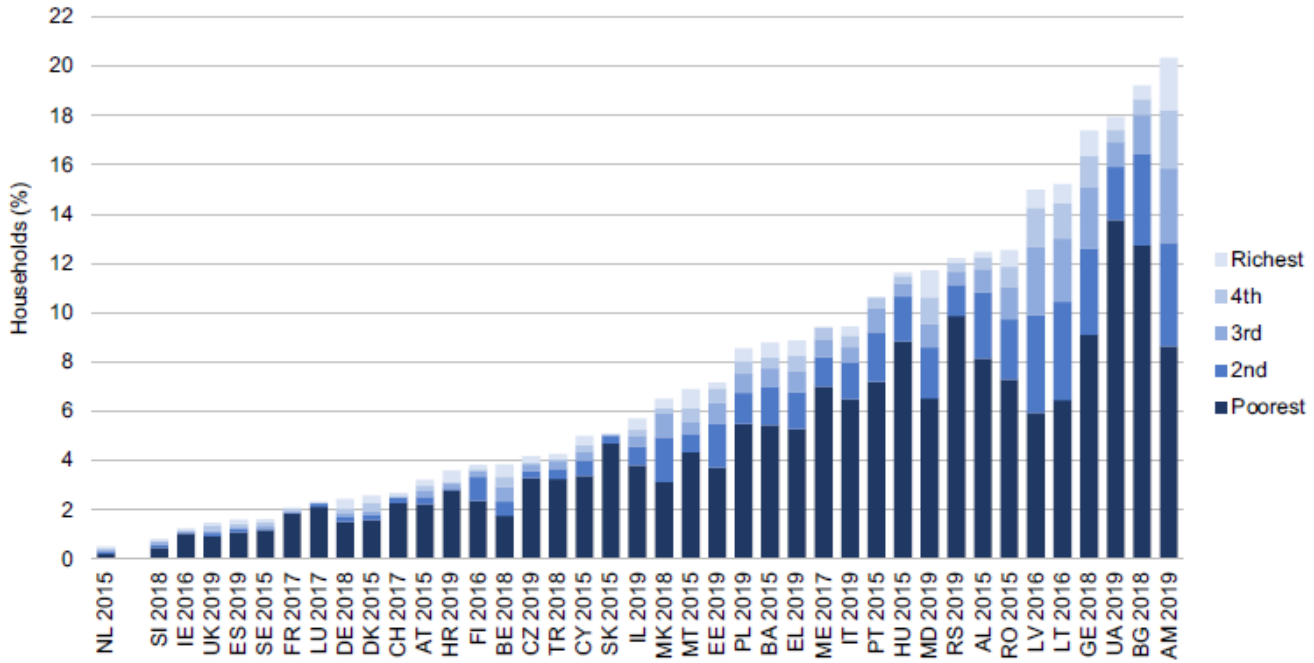


# Health and care in the UK

## Strengths

- One of the lowest levels of catastrophic health spending internationally
- A healthcare financing system that collectively facilitates redistribution from the rich to the poor

**Share of households with catastrophic health spending by consumption quintile, 2019 or the latest available year**




Source: Thomson et al 2024

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# 10 Aims for 10-year planning
## (with some proposals for improving quality and capacity)

Professor Alistair McGuire, LSE

# UK NHS

- *”The astonishing fact is that Bevan's vision has stood both the test of time and the test of change unimaginable in his day. At the centre of his vision was a National Health Service, and sixty years on his NHS  by surviving, growing and adapting to technological and demographic change remains at the centre of the life of our nation as a uniquely British creation, and still a uniquely powerful engine of social justice." (Gordon Brown, UK Prime Minister, 2008)*

- NHS is a social I**NSURANCE** system – maintain financial security of individuals

# The NHS is a Social *INSURANCE* system

- Aim 1 - Treasury ***commitment*** *to 10-year funding* for 10-year plan
  - Physician training requires 5-yr degree, 2-year foundation training and 5-8 years specialist training (anywhere between 10 (for GPs) – 15 yrs training (to reach consultant level)) & specialist nursing training is >5 years generally
  - 10-year funding commitments should be the norm to align Fiscal cycle with workforce planning cycle; will help with capital planning also
  - Establish a **fully independent** (akin to OBR) institution to provide oversight on NHS funding, workforce, delivery of services & outcomes
  - This Institute should promote our social insurance system by improving 'billing/cost' information and identify areas of disinvestment in low value care (as begun but not fully initiated by the Evidence Based Interventions programme; large efficiency gains unrealised here)
- Aim 2 –
  - Ensure the NHS is seen as a social insurance system with a defined benefits package (drawing on NICE and local clinical guidelines)
  - Every patient journey initiated and maintained with a contract (given by GP) on what to expect when and by who as their diagnosis and treatment progresses (GP will need additional funding for this)
  - Promote a system designed to follow the patient journey (e.g. follow the money), and ensure that *provider incentives* are aligned to ensure delivery of high-quality care and meet quality targets

# Aim 3 – Promote provider Prevention activities

- Work with Treasury to find ways to promote prevention expenditure within the annual expenditure rounds and multi-year plans
  - Could be done within the existing public sector accounting rules *IF* primary prevention is tied to some "notional assessment" of providing net income/benefits so prevention expenditure is offset (as an asset) against future net income
    - Maybe estimated as an income from future savings from care services or seen to cross-subsidise care services within the health sector (proven savings elsewhere from prevention – NICE evidence here is supportive)
    - But criticism will be what's different about health from education or other public expenditure???
  - Consider Restructuring of charging for prevention services through an s102 Order (Finance Act 1987) to lower cost of certain primary prevention services (cost below charge and incorporate within GP budgets)
    - See Public Dividend Capital https://assets.publishing.service.gov.uk/media/65c4a3773f634b001242c6b7/Managing_Public_Money_-_May_2023_2.pdf
  - Change the public sector accounting rules so prevention is seen as an investment rather than a cost or discounting of benefits not applied to RoR estimates
    - BIG ask!

# Aim 4 – Improve Primary Care and GP access

- Update the current regulation of the GP appointment provision and allow greater choice of GP practice (efficiency savings here)
  - Current regulation (an outdated KPI estimate by McKinsey) for 72 F2F appointments per 1,000 patients per week
  - Needs updated to reflect new ways of working, to encourage appropriate "virtual" appointments, repeat appointments, appointments with non-GP staff etc. (implicitly assumes an "optimal" mix of staff
  - Current choice based on catchment areas – this should be widened, but regulated to avoid leaving practices with costly patients than cannot exercise choice (think about enforced mergers here?)
  - Double registration an issue here – which affects funding
- Publish full information publicly on GP practices
  - Including time to consult, consult times/rates; number of GPs/nurses/GP assistants' substitutions; additional forms of appointment (e.g. monthly dermatology clinics/paediatric clinics/ etc.)
- Expand GP targets and payments/penalties through the Quality and Outcomes Framework (QoF)
  - Include patient integrated outcomes (such as Avoidable hospitalisations, time to diagnosis, time to referral) into the targets and link to payments
  - Enhance online bookings and to be within a target time period, complimented with telephone access (with ring back) for those not digitally literate
- Institute a patient level sample survey within each GP practice on a quarterly basis of **health** outcomes ( QALYs?) before and after primary/secondary care treatment, and eventually link to payments

# Aim 5 – Improve Secondary care (hospitals)

- Use Budget monies (the £25bn) to set up (independent?) diagnosis centres, like the breast cancer (and other) screening centres but for a fuller range of diseases
  - Hospitals are too often associated with late diagnosis. High quality care needs early (and on-going) diagnosis for primary and secondary prevention and for early treatment. These Centres would also carry out blood and genetic screening (at each visit) for various diseases. Information held by such centres to include all risk factor information (family histories etc) GP referral rates in their targets
- Encourage hospitals to have outreach clinics in GP practices (i.e. such as dermatology clinics) or to incorporate GP practices within hospitals (as is occurring already in some hospitals…)
  - Comprehensive secondary prevention targets (as important as primary prevention) to be included in GP QoF targets
- More surgical theatres need to be built based on estimates of "reserve capacity" with accompanying "Recovery wards" (to manage high throughput), removing the need to block CCU beds after surgery, disrupting throughput and discharge policies
- Initiate hospital discharge rights by allocating a *discharge budget* to cover all hospital discharges and to liaise with Local Authorities
  - Pay some fractional amount of budget to be matched with Local Authorities to cover community care) and community care (including homes, community care nurses)
  - This is not the NHS Better Care Fund (BCF), but could be seen as a full extension of this
- If supplementing NHS hospital care with private care, subject private care to same data requirements, payments, and regulations as the NHS
  - Where more than a given treatment percentage is contracted to the private sector NHS providers get additional levy in tariff to account for market advantage private providers have, to create level playing field, and to promote NHS treatment retention
- Over longer-term hospital payments to reflect health outcomes, (or at least quality improvements), not just patient flows

# Aim 6 – Improve Mental Health Care

- Mental health care is **not** working at all
- Use some of the released £25bn to establish improved mental health day centres which individuals with mental health care attend to have comprehensive ongoing care for their chronic condition
  - If individuals receive disability benefits (unless physically impossible) they must attend to receive these payments if linked to mental health and to pick up prescriptions: If not attending send outreach community care workers to home address
  - Address supply staffing issues with increased counsellors, carers, increase use of professional crises teams
  - Tie budgets to health improvement outcomes

# Aim 7 – Improve current Procurement and Cost systems

- There should also be a national Procurement Office, a truly UK wide national body, for all supplies that can be procured e.g. for medical devices, hips, diagnostic machines, surgical robots, materials, software, etc
  - Software (for patient records at the GP, hospital and community levels; so, each level interfaces with each other and follows each patient episode from beginning to end, noting all service delivery and is linked across a patient's lifetime)
  - Excluding drugs which has a separate well-working process
- Central purchasing should be compulsory
  - Unless for a confirmed cost-saving, patient benefit reason that is pre-negotiated with Trust and the new body
  - Efficiency gains unrealised here
- This body extends and enhances the existing NHS Supply chain
  - NAO (2024) says this is not working
- Finalise the Patient Level Information and Costing (**PLICs**) system for individual patient costing and extend data to cover the patient journey from entering the NHS at GP level right through to the community level
  - Would help with differential reimbursement systems for public and private providers to limit negative implications of market advantage private providers have as they can cream-skim and select less costly patients
  - Make data available to all NHS bodies and relevant research teams in conjunction with NHS HES and outcomes data (join HES to ONS data routinely)

# Aim 8 – Workforce Planning

- The NHS employs some 1.5 million staff (accounts for 46% of the budget) and is already on the backfoot in terms of planning, expenditure, vacancies, etc (see Health Foundation/Kings Fund funding figures to underpin the existing workforce plan)
- Better **national** (i.e. UK) coordination of workforce supply and demand is required
  - USA type central matching system required to match graduates to specialities and coordination required across all UK nations
- Establish a national workforce planning unit to estimate hours worked, track shortages across different areas and specialities, turnover, etc.
  - Currently the NHS know the number of FTEs but not hours worked, where turnover movers go, specialty mixes, staff level mixes at different hospitals, etc. etc. Staff data is relatively poor and based on payroll figures: Consequently, little on primary care staffing
- Some staffing practices are just out-of-date! Survey, review, change…

# Aim 9 – Improve NHS management practices

- The NHS is under managed and over administered
  - Administration important for data collection, collation and reporting
  - This needs to be retained AND feedback to patients improved…but this is administration…
- Management important for efficiency
  - Set up high level health system management training (aimed at clinicians and “high-flyer” Civil Servant types?)
  - Reward NHS managers adequately (currently difficult to manage a fiefdom of higher paid consultants??) BUT tie to explicit targets, objectives, population health outcomes
  - Differentiate between MANAGERS and Operating (administrative) officers
- Emphasise the NHS as a social INSURANCE system
  - Needs data administrators, feed back of information to managers, health care workers & patients but also requires strategic management

# Aim 10 – Extend into Social Care and evidence base all policies

- Social care should be part of a ***national*** coordinated picture with the NHS
  - The **National** Health Service is **not** national in coordination, particularly with with Las (some exceptions…)
  - Compulsory and comprehensive survey of existing discharge and community care services (which varies by LA)
  - Existing Better Care Fund plans are LA determined, with no parameters to guide BCS (and little LA resource)
  - Home First packages, for clinical discharge, not coordinated and not well-funded (except through existing LA monies) with severe shortages of reablement care (increased need for physiotherapy, speech therapy, occupational therapists, community nursing)
  - Tax property to initiate social care funding
- **ALL** system change initiatives should be backed by evidence and/or piloted before introduction

# Social care and the NHS

## LSE Health panel session

Catherine Henderson, Care Policy and Evaluation Centre, LSE

4th June 2025

# Background

- NHS – free at the point of access, many services provided 'in-house'
- 'Social care'…
  - not only 'long-term care' (LTC) but also myriad other supports [1]
    - provided not only by councils
    - features 'mixed economy of care', with unpaid care and support primarily provided by private and not-for-profit/voluntary organisations
    - Approx. 1.7 million adult social care jobs in England (1.3 million NHS jobs)
    - unpaid care worth more than 5 times social care expenditure)[2]
  - interface with other sectors - NHS, but also education, criminal justice, housing

# Challenges of health and social care divide

- Social care access (mostly) based on need and ability to pay (means-testing); NHS access based on *need* for care
- Administrative, financial, professional culture drivers of division of care between NHS and social care [3, 4]
- Problems arise at interface for people with short- and long-term needs for social *and health* care in access to *appropriate* care:
  - supply of restorative support (NHS and social services), variations in funding for LTC and access to NHS continuing care depends on condition, geographies
  - framed in terms of NHS issues – emergency hospital admissions, delayed discharges – and driving policymaking [4,5,6]
- Demographic change – double the numbers of people 85+ by 2047 [7] and of people living with dementia by 2040[8], 93% rise social care spending 2038 [9]

# Solutions

## Bridging the divide - short term services

- Policy makers look to integration to solve longstanding NHS problems in managing utilisation of the acute care system:
  - Many routes: better co-operation, better coordination, colocation, joint commissioning & pooled budgets, personal budgets [10,11,12]
- Efforts underpinned by legislative changes,[1] new funding mechanisms
  - Better Care Fund, Integrated Care Boards and Partnerships [2, 13, 14]
  - improving access to free *short-term* services bridging acute hospital/community care funding boundary: intermediate care, reablement, rehabilitation: some evidence effective/cost effective for older people, homeless people [15-18]
- Progress in the last 15 years in widening access to short term social care support (but ≠ reducing use of acute hospitals) [19, 20]

1. Health Act 1999 'Flexibilities'; Community Care (Delayed Discharge) Act 2003; section 75 of the NHS Act 2006; Care Act 2014; Health and Care Act 2022

# Ongoing challenges

## Sustainable and fair funding models for LTC?

- Paying the whole cost of LTC often falls to individuals and families with the risk of catastrophic care costs for some [2,19,21]
- Growing number of people living with dementia, encountering a fundamentally unfair system [22-25]
- Several commissions on LTC funding since 1999 but no wholesale reform in England as yet [26]. Scotland – free personal care
- Other government departments: poor, cold and unsuitable housing contributes to NHS and LTC costs [27]

*"In England access to social care support is means tested, unlike the NHS which is free when people need it. The difference is huge: no one is asked about their house value if they need medical treatment for cancer, yet if they need social care because of dementia that is exactly what happens. This level of means testing also sets England apart from many other progressive, developed countries such as Germany, Japan and Denmark"*
https://www.kingsfund.org.uk/insight-and-analysis/blogs/labour-cap-on-care-costs

# Decisions for the government and the public

## Expenditure on NHS and LTC

- Public understanding of LTC funding, willingness to pay for sustainable funding model via taxation[28, 29], 'cost of inaction'
- Public understanding of dementia – health condition, not normal ageing, high use of social and unpaid care [30-32]
- Workforce with appropriate training, sufficient to meet projected HSC needs
- HSC infrastructure – digitalisation, data management, information standards for data sharing across NHS and social services

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# THANK YOU.

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LSE CPEC CARE POLICY & EVALUATION CENTRE

# The NHS at 77: a national treasure or a system in crisis?

## Speakers:

### Dr Michael Anderson

Senior Visiting Fellow, LSE Health, and NIHR- funded Clinical Lecturer at the University of Manchester

### Professor Andrew Street

Professor of Health Economics and Head of the Department of Health Policy

### Professor Alistair McGuire

Professor of Health Economics and Chair of LSE Health

### Dr Catherine Henderson

Assistant Professorial Research Fellow at LSE's Care Policy and Evaluation Centre (CPEC)

## Discussants:

### Dr Jennifer Dixon DBE

Chief Executive of the Health Foundation

### Professor Sir Julian Le Grand

Professor of Social Policy, LSE Marshall Institute for Philanthropy and Social Entrepreneurship

## Chair:

### Professor Elizabeth Stokoe

LSE Academic Director of Impact