REFORM

REIMAGINING HEALTH

A framing paper

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ABOUT REIMAGINING THE STATE

After a decade of disruption, the country faces a moment of national reflection. For too long, Britain has been papering over the cracks in an outdated social and economic model, but while this may bring temporary respite, it doesn't fix the foundations. In 1942 Beveridge stated: "a revolutionary moment in the world's history is a time for revolutions, not for patching." 80 years on, and in the wake of a devastating national crisis, that statement once again rings true. Now is the time to fix Britain's foundations.

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INTRODUCTION: REIMAGINING HEALTH

In its early years, our National Health Service proved visionary. It provided high-quality care to meet the dominant needs of the population it served: timely, universal access to episodic, acute treatment.

When the NHS was established, the average life expectancy in England was 66 for men and 70 for women, more than a decade less than we can expect to live now.[1] Only 11 per cent of the population were aged 65 and over, a number that has now risen to 19 per cent. Many of the pioneering medical innovations that revolutionised modern healthcare had not been invented and conditions that dominate healthcare usage and expenditure today – chronic pain conditions, diabetes, and dementia – were either rare or poorly understood.

The structures and institutions designed to meet the challenges of the post-war world are not equipped to deal with our current and future health challenges. We now find ourselves with a system that doesn't work for patients, who too often struggle to access high-quality timely care; for medical staff, who feel disempowered, stressed, and burnt out; or for taxpayers, who foot an increasing bill for a service which is struggling to cope.

Successive governments have tried to tweak our current model. Since 2000, we have seen multiple system restructures and substantial injections of additional money. Yet all have failed to move the dial on health outcomes.

Reform efforts have been hampered by a narrow and often ideological debate. The conversation often starts with the wrong questions – how to "fix" the NHS rather than how to boost the health of the nation, how to meet demand in the healthcare system rather than how to reduce and divert it, and how to optimise the current delivery model rather than how to rethink it to meet new challenges. Too much time is spent discussing whether the NHS is at risk of privatisation, rather than how to ensure a sustainable model for the future.

Shifting the terms of this debate is vital – without a radical rethink, our system will continue its current trajectory, moving from crisis to crisis. But more importantly, the prize available if we pursue a bold approach is immense – a healthier, and therefore more prosperous, nation. It's time for bold thinking, not short-termism. It's time to reimagine health.

[1] Office for National Statistics, *2016 Based England and Wales Period Life Expectancies, 1948 to 2016*, 2018.

1. DIAGNOSING THE PROBLEM: POOR ACCESS AND OUTCOMES AT INCREASING COST

High-performing health systems are relentlessly focused on delivering the best outcomes for citizens, providing timely access to high-quality care, and achieving value for the taxpayers who fund them. All of these goals must be achieved in a sustainable budgetary envelope. Our health system is currently falling short on each of these fronts.

1.1 EVER INCREASING COSTS

Throughout its history, we have continued to spend increasing amounts on our healthcare system. However, spending increases have been particularly significant in recent decades and are projected to continue. By 2024-5, the Department of Health and Social Care budget will represent 46 per cent of all Whitehall controlled day-to-day departmental spending, up from 32 per cent in 2004-5.[2]

By 2024-5, £84 billion of the £111 billion a year increase in day-to-day departmental spending since 2009-10 will have gone to the Department of Health and Social Care,[3] of which around 85 per cent will be spent on health (not social) care.[4]

Before the pandemic, health spending – not including social care – accounted for 8 per cent of GDP.[5] In 2020, the OBR predicted that this will exceed 10.5 per cent in 2040, and in 50 years' time, with today's young people in retirement, our health service is set to account for 14.8 per cent of GDP.[6] As the OBR states, in large part due to these forecasts, health spending is the "largest – and most likely – source of long-term risk to fiscal sustainability".[7] Given the 2021 Autumn Budget and Spending Review's commitment to increase health funding from £144.9 billion to £188.6 billion[8] – a 4.1 per cent annual growth rate – by 2024, future forecasts could be even higher.

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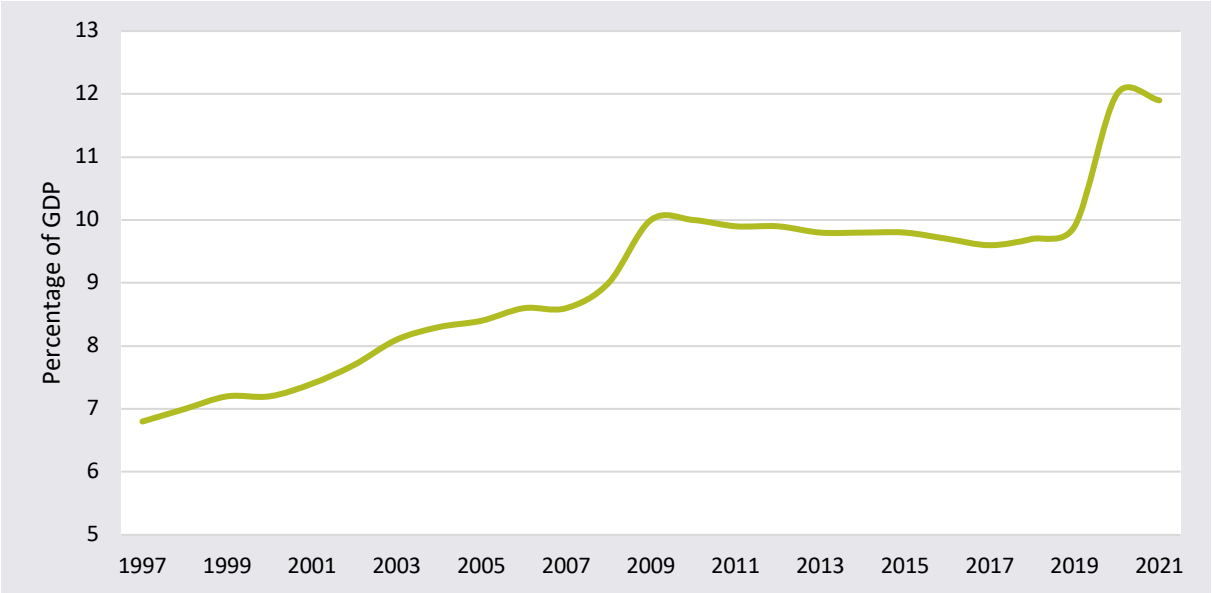
[2] Torsten Bell et al., *The Boris Budget: Resolution Foundation Analysis of Autumn Budget and Spending Review 2021* (Resolution Foundation, 2021). Specifically, day-to-day Whitehall controlled departmental spending excludes Annual Managed Expenditure (AME) and capital expenditure.
[3] Ibid.
[4] NHS Digital, *Adult Social Care Activity and Finance Report, England - 2020-21*, 2021.; HM Treasury, *Autumn Budget and Spending Review 2021: A Stronger Economic for the British People*, 2021.
[5] Office for Budget Responsibility, *Fiscal Sustainability Report: July 2018*, 2018.
[6] Ibid.; Office for Budget Responsibility, *Fiscal Sustainability Report: July 2020*, 2020.
[7] Office for Budget Responsibility, *Fiscal Sustainability Report: July 2020*, 2020.
[8] HM Treasury, *Autumn Budget and Spending Review 2021: A Stronger Economic for the British People*.

Figure 1: Healthcare spending as a percentage of GDP



Source: ONS, *Health expenditure, UK Health Accounts provisional estimates: 2021,* 2022

Public service expenditure can grow sustainably if it does so in line with national economic growth. Yet forecasts for the coming decade suggest that any hope that economic growth will offset increased health expenditure is unrealistic. Even before the pandemic, the OECD predicted that growth in health expenditure would likely outpace GDP growth until at least 2030.[9]

This would fit with a long-run historic pattern – healthcare expenditure growth has tended to outstrip GDP growth since the inception of the NHS.[10] With major commitments to increase NHS spending after the pandemic and a worsening economic outlook, this imbalance between healthcare expenditure and growth is likely to increase further.[11]

In the absence of sustained economic growth, rising health expenditure can be financed through increased taxation or borrowing, redirecting spending from other public services, or diversifying the funding model for healthcare (see section 5.3). Each of these is politically challenging.

The UK's tax burden is currently at its highest sustained peacetime level, with the Government having already increased National Insurance specifically to pay for health and social care. Further tax increases look unlikely – the current Government has already committed to significant tax cuts and to reversing the recent national insurance increase,

[9] Organisation for Economic Cooperation and Development, 'Health Spending Set to Outpace GDP Growth to 2030', Webpage, 7 November 2019.
[10] Office for Budget Responsibility, *Fiscal Sustainability Analytical Paper: Fiscal Sustainability and Public Spending on Health*, 2016.
[11] Office for Budget Responsibility, *Economic and Fiscal Outlook - March 2022*, 2022.

now named the Health and Social Care Levy.[12] There is also a growing sense among the public that the NHS should "live within its means" rather than be the recipient of extra revenue from taxation.[13]

Borrowing to finance healthcare expenditure is another possibility. However, public sector net borrowing remains at historically high levels in the aftermath of the pandemic and debt servicing costs are rising quickly.[14] Increased borrowing entails major long-term macroeconomic risks, particularly where it is used to fund day-to-day spending rather than long-term investment. Both major parties are committed to fiscal rules which preclude borrowing to finance day-to-day spending, so options in this area are limited.[15]

The only remaining option to finance increased health expenditure, absent a change in funding model, is to redirect spending away from other areas. This has also been a long-term trend in government spending. The so-called 'peace dividend' (a decreased need for defence spending in a more stable world) allowed for increases in welfare spending, particularly on health,[16] but there are no further dividends to come. In fact, given the state of geopolitics, defence spending looks set to once again increase.

This historic trend has been accentuated over the last decade – governments have chosen to prioritise health over all other areas of public expenditure. The NHS budget has continued to grow year on year, albeit at a historically low rate, while other public services have seen their budgets reduced.[17]

While this may reflect public prioritisation of the NHS over other services, it is not clear that spending more on healthcare would solve the problems our health system faces. Despite spending more, we are not achieving improved outcomes. Accessing care is becoming more difficult, we trail our neighbours on several key treatment outcomes, and the health of the nation is deteriorating. See Section 4.2 for a further discussion of funding trade-offs.

1.2 POOR ACCESS

Being able to access high-quality care at the point of need is a key indicator of health system performance. Poor access leaves patients feeling anxious, leads to deteriorations in health status, and delayed treatment often means higher care costs in the long-term. Unfortunately, access to care remains a core challenge for our health system.

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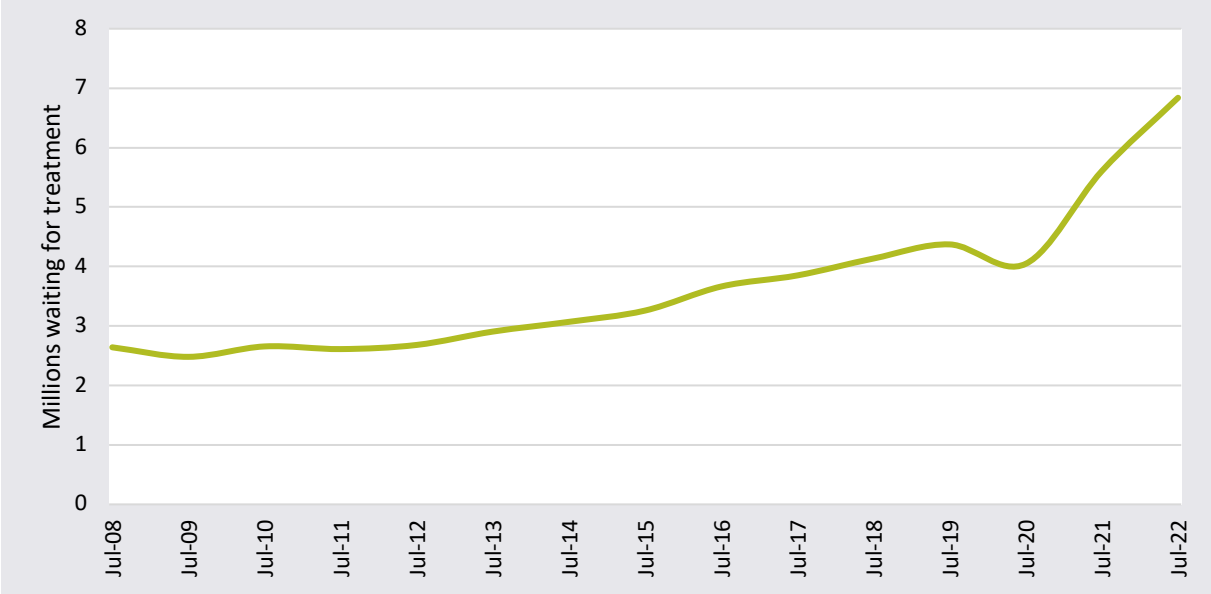
[12] Torsten Bell and Adam Corlett, *Talking Tax: What's Been Said and What's Gone Unsaid in the Conservative Leadership Election* (Resolution Foundation, 2022).
[13] Dan Wellings et al., *Public Satisfaction with the NHS and Social Care in 2021: Results from the British Social Attitudes Survey* (The King's Fund and Nuffield Trust, 2022).
[14] Office for National Statistics, 'Public Sector Finances, UK: July 2022', Webpage, 19 August 2022.
[15] Carl Emmerson and Isabel Stockton, 'Rewriting the Fiscal Rules', in *IFS Green Budget 2021*, Carl Emmerson, Paul Johnson, Ben Zaranko, 2021.
[16] Ben Zaranko, 'Defence Cuts Effectively Paid for UK Welfare State for 60 Years – but That Looks Impossible after Ukraine', *The Conversation*, 7 March 2022.
[17] Michael Anderson et al., *United Kingdom: Health System Review 2022* (European Observatory on Health Systems and Policies, 2022).

Waitlists for elective treatment are at a record high, with 6.83 million people waiting in July 2022.[18] More than 377,000 people have been waiting for over a year, and more than 2,800 have been waiting for over two years.[19] While COVID has clearly had an effect on waitlists, even before the pandemic waitlists were a major challenge. Indeed, the last time waitlists for elective treatment were below 3.5 million was in early 2016.[20]

Figure 2: Growing backlog for NHS elective treatment

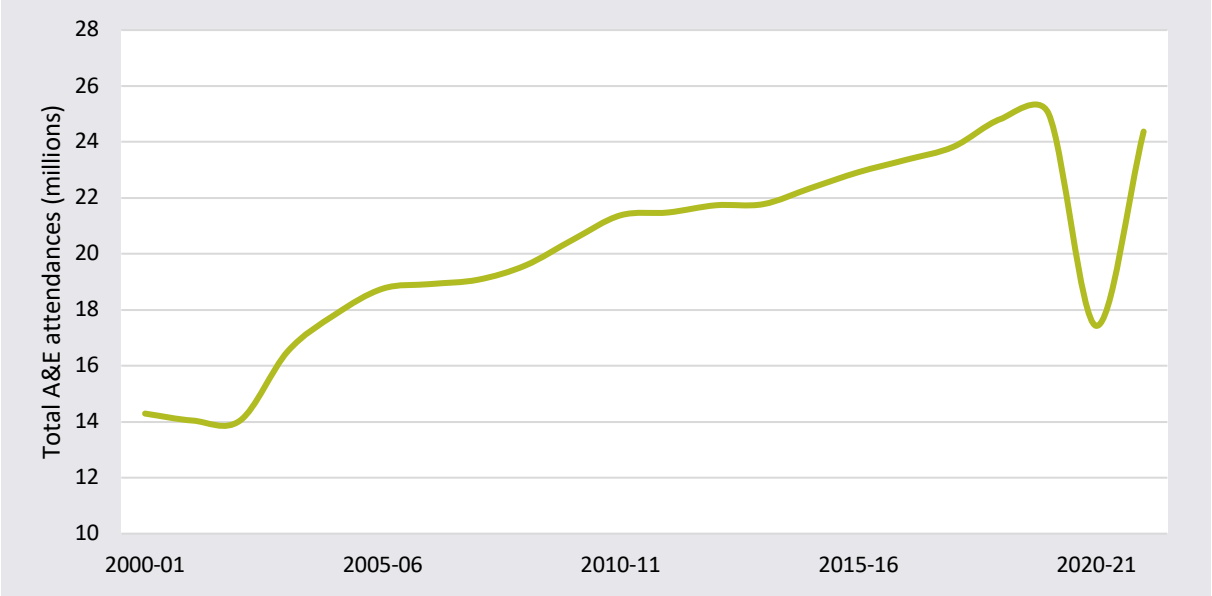


Source: NHS Digital, *Consultant-led Referral to Treatment Waiting Times: July 2022*, 2022; Comparable data begins in August 2007

In Accident and Emergency departments, demand has grown by 70 per cent over the last two decades, from 14 million annual attendances in 2000-1 to 24 million in 2021-2.[21] In that same period, the population of England grew by only 20 per cent.[22] The NHS has been unable to meet its waiting target – that 95 per cent of patients are admitted, discharged or transferred within four hours – since 2015.[23]

[18] NHS England, *Consultant-Led Referral to Treatment Waiting Times Data: July 2022*, 2022.
[19] Ibid.
[20] NHS England, *Consultant-Led Referral to Treatment Waiting Times Data: July 2022*.
[21] NHS England, *Quarterly Attendances & Emergency Admission Monthly Statistics, NHS and Independent Sector Organisations in England: July 2022*, 2022.
[22] Office for National Statistics, *Estimates of the Population for the UK, England and Wales, Scotland and Northern Ireland*, 2021.
[23] NHS England, *Quarterly Attendances & Emergency Admission Monthly Statistics, NHS and Independent Sector Organisations in England: July 2022*.

Figure 3: Increasing A&E attendances over time



Source: NHS Digital, *A&E Attendances and Emergency Admissions: August 2022,* 2022

In other areas, overwhelming demand means that care is essentially rationed to those with the most acute problems, leaving millions of people with un- or under-met needs. This is particularly acute in the case of social care – it is estimated that 1.5 million people over the age of 65 (one in seven) have unmet care needs.[24] This is also the case when it comes to mental health – NHS leaders estimate that 8 million people who would benefit from mental health support are unable to access it as they don't meet high access thresholds.[25] These 'hidden' waitlists are often poorly reported but suggest that published data on demand for healthcare is just the tip of the iceberg when it comes to our health system's access crisis.

Underfunding is one of the most frequently cited reasons given for this unintentional rationing of care, and it is certainly true that cash injections during former Prime Minister Tony Blair's administration led to impressive reductions in waiting times in the late 2000s: 18-week wait targets were first achieved in 2008, while, for example, the number of patients waiting more than 13 weeks from referral by a GP to first outpatient attendance fell from 396,000 in 2000, to 157 in 2006.[26]

However, the cash injections required to achieve this were larger in real terms than in any other period in the last 30 years, averaging 8.2 per cent between 2001 and 2005 (more than

[24] Age UK, *General Election Manifesto 2019*, 2019.
[25] Saffron Cordery, 'The Long-Term Need for Continued Government Investment for Mental Health Services', *NHS Providers*, 31 August 2021.
[26] Richard Murray, 'Lessons from the 2000s: The Ambition to Reduce Waits Must Be Matched with Patience and Realism', *The King's Fund*, 29 July 2021.

three times the average GDP growth during this period), and above 5 per cent after that.[27] As we have seen, this is unsustainable.

It is also worth noting that some of the accompanying reforms also likely had an impact beyond just spending more. In particular, the introduction of Payment by Results in 2004, which largely replaced block payments to acute providers with payment by activity, unsurprisingly increased hospital activity.[28]

Perhaps most importantly, productivity declined over the period – by an average of 2 per cent a year between 2001 and 2005 – and outcomes in key areas, such as gaps in life expectancy between the most deprived areas and the rest of the country, continued to get worse.[29] More money alone will not solve our national health and care crisis.

1.3 INTERNATIONALLY POOR OUTCOMES

When it comes to judging the performance of health systems, the key question must be: does the system achieve good health outcomes for patients?

Whilst the UK performs well on certain care outcomes – for instance, in relation to avoiding diabetes related hospitalisation and kidney disease treatment[30] – the table below shows that on the most important care outcomes (those related to mortality) the UK trails other high-income nations. For the two leading causes of cancer death worldwide (breast and lung cancer), the UK performs in the bottom half of OECD countries.[31]

We also perform in the bottom half for the most common type of stroke (ischaemic strokes),[32] and infant mortality[33] – considered to be one of the most important indicators of health system effectiveness, because of its close association with the social and economic determinants of health.[34] Perhaps most worryingly, we are in the bottom half of countries when it comes to treatable mortality (mortality rates from causes that should not be fatal if effective healthcare is in place).[35]

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[27] John Appleby, Rowena Crawford, and Carl Emmerson, *How Cold Will It Be? Prospects for NHS Funding: 2011-17* (The King's Fund and Institute for Fiscal Studies, 2009).

[28] Shelley Farrar et al., 'Has Payment by Results Affected the Way That English Hospitals Provide Care? Difference-in-Differences Analysis', *BMJ Open* 339, no. b3047 (August 2009).

[29] House of Commons Health Committee, *Public Expenditure on Health and Personal Social Services 2008*, HC 1190 (London: The Stationery Office, 2008).; Department of Health, *Autumn Performance Review*, 2006.

[30] OECD, 'Diabetes Care', Webpage, 2021.; Mark Dayan et al., *How Good Is the NHS?* (The Health Foundation, The Institute for Fiscal Studies, The King's Fund, and The Nuffield Trust, 2018).

[31] OECD, 'Cancer Incidence and Mortality', Webpage, 2019.

[32] OECD, 'Mortality Following Ischaemic Stroke', Webpage, 2019.

[33] OECD, 'Infant Health', Webpage, 2019.

[34] Daniel D. Reidpath and Pascale Allotey, 'Infant Mortality Rate as an Indicator of Population Health', *Journal of Epidemiology and Community Health* 57, no. 5 (May 2003).

[35] OECD, 'Avoidable Mortality (Preventable and Treatable)', Webpage, 2021.

Figure 4: Health outcomes across key indicators

Rank	Avoidable Mortality	Infant Mortality	Breast cancer survival rate	Ischaemic stroke survival rate
1st	Switzerland	Slovenia	Iceland	Costa Rica
2nd	Iceland	Iceland	United States	Japan
3rd	Israel	Japan	Australia	Korea
4th	Italy	Finland	Japan	Norway
5th	Spain	Sweden	Sweden	Iceland
6th	Japan	Czech Republic	Finland	Turkey
7th	Sweden	Norway	Portugal	United States
8th	Norway	Estonia	Israel	Denmark
9th	Australia	Italy	Canada	Netherlands
10th	Netherlands	Luxembourg	Costa Rica	Switzerland
11th	France	Spain	New Zealand	Sweden
12th	Luxembourg	Portugal	Norway	Israel
13th	Korea	Austria	France	Germany
14th	Ireland	Korea	Korea	Australia
15th	New Zealand	Israel	Switzerland	Colombia
16th	Canada	Germany	Netherlands	Austria
17th	Belgium	Ireland	Belgium	Italy
18th	Portugal	Australia	Denmark	France
19th	Austria	Belgium	Spain	New Zealand
20th	Germany	France	Germany	Canada
21st	**United Kingdom**	Netherlands	Italy	Ireland
22nd	Greece	Greece	**United Kingdom**	Finland
23rd	Finland	Latvia	Austria	Belgium
24th	Denmark	Lithuania	Slovenia	Chile
25th	Costa Rica	Switzerland	Turkey	Luxembourg
26th	Slovenia	**United Kingdom**	Ireland	Estonia
27th	Chile	Denmark	Czech Republic	**United Kingdom**
28th	Colombia	Poland	Chile	Spain
29th	Czech Republic	Hungary	Estonia	Czech Republic
30th	Turkey	Canada	Latvia	Slovakia

Source: OECD, *Health Status and Healthcare Quality Indicators*, 2014; Table left blank where OECD country data was not available, OECD data records the UK as a whole and does not disaggregate constituent nations

While we should be concerned about health outcomes in general, we should be particularly alarmed by health inequalities. Despite paying long-term lip service to closing the health gap, disparities remain stubbornly wide and in some instances are growing.

The gap in healthy life expectancy between the least and most deprived areas is high and growing – those living in the most deprived areas can expect almost two decades less of healthy life than those in the least deprived areas.[36] People in the bottom 40 per cent of the income distribution are around four times as likely to report bad or very bad health than those in the top 20 per cent.[37]

"A high level of health inequality left the UK particularly vulnerable to the effects of the COVID-19 pandemic."

Significant disparities also exist in terms of access to healthcare. There are fewer GPs per head (45 per 100,000 patients) in the most deprived areas than in the least deprived (49 per 100,000), despite the former having a far higher burden of ill health.[38] Furthermore, access to NHS funded elective treatment is higher in the least deprived areas than the most.[39]

Alongside inequalities based on socio-economic deprivation, racial disparities in health outcomes and access to care are also prevalent. Black women are four times more likely to die in childbirth than white women;[40] and the mortality rate for black and Asian infants is twice as high as for white infants.[41] Patients from minority groups also report poorer experience of a range of health services than their white British counterparts.[42]

A high level of health inequality left the UK particularly vulnerable to the effects of the COVID-19 pandemic. During the first wave of the pandemic, black men were 3.7 times more likely to die than white British men and during the second wave, Bangladeshi men were five times more likely than white men to die.[43] Those living in the most deprived areas were almost twice as likely to die from COVID as those living in the least deprived areas.[44]

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[36] Office for National Statistics, *Health State Life Expectancies by National Deprivation Deciles, England: 2018 to 2020*, 2022.
[37] The Health Foundation, 'Relationship between Income and Health', Webpage, 19 April 2021.
[38] Rebecca Fisher et al., *Briefing: Level or Not? Comparing General Practice in Areas of High and Low Socioeconomic Deprivation in England* (The Health Foundation, 2020).
[39] Steven Wyatt and Jake Parsons, *Socio-Economic Inequalities in Access to Planned Hospital Care: Causes and Consequences* (The Strategy Unit, 2021).
[40] *Saving Lives, Improving Mothers' Care: Lay Summary 2021* (National Perinatal Epidemiology Unit, University of Oxford, 2021).
[41] Office for National Statistics, *Births and Infant Mortality by Ethnicity in England and Wales: 2007 to 2019*, 2021.
[42] Veena Raleigh and Jonathan Holmes, 'The Health of People from Ethnic Minority Groups in England', *The King's Fund*, 17 September 2021.
[43] Mehrunisha Suleman et al., *Unequal Pandemic, Fairer Recovery* (Health Foundation, 2021).
[44] Office for National Statistics, *Deaths Involving COVID-19 by Local Area and Socioeconomic Deprivation: Deaths Occurring between 1 March and 31 July 2020*, 2020.

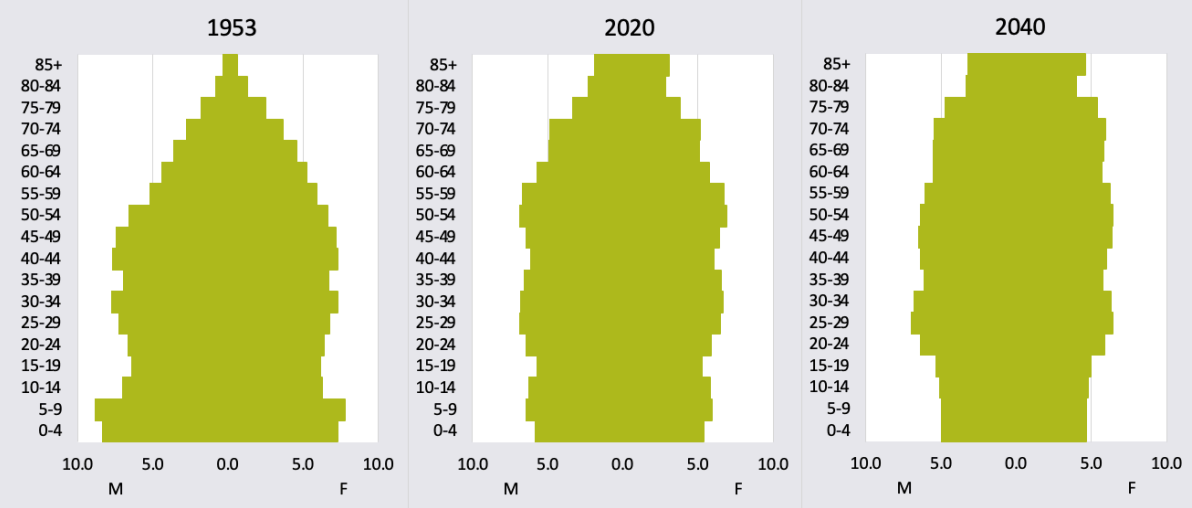
2. THE LONG-TERM PROGNOSIS: FURTHER DETERIORATION

Our health system is already struggling to deliver for patients and taxpayers, and, under our current model of care, demographic and social change will see this situation deteriorate further. On current projections, we are likely to face more severe cost pressures, deeper challenges in accessibility, and stagnating outcomes.

2.1 POPULATION AGEING

In the first instance, demographic trends will have a significant impact on our ability to pay for and deliver care. Like many other high-income countries, the UK has an ageing population. By 2030, one in five people in the UK will be aged over 65,[45] and by 2066 it will be one in four.[46] The proportion of the population aged 85 and over will have tripled by 2066.[47]

Figure 5: Changing age composition of UK population

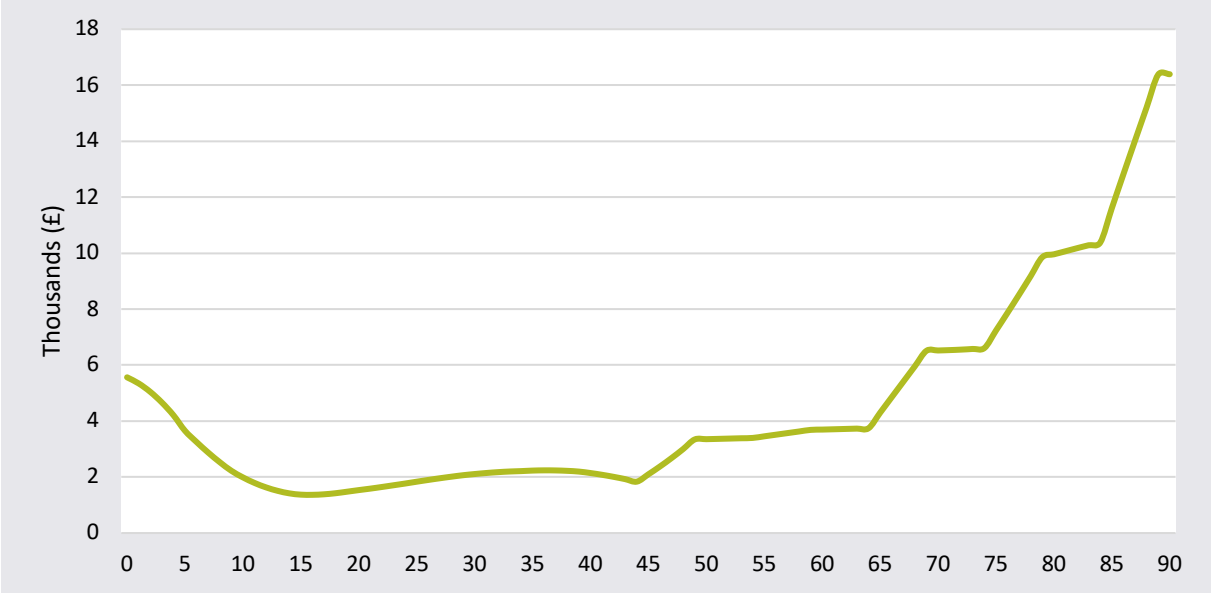


Source: ONS, *National population projections: 2020-based interim,* 2022

Population ageing poses two major challenges to our health and care system: higher costs, funded by fewer people. In the first instance, it drives up demand for, and the cost of, care. While the cost of providing healthcare depends on a range of factors, on average, the cost of caring for older people is far higher than for young people. The average cost of providing care for a 65-year-old is double that of a 30-year-old. The average cost of providing care for an 85-year-old is more than double again.[48]

[45] *Later Life in the United Kingdom* (Age UK, 2019).
[46] Office for National Statistics, 'Living Longer: How Our Population Is Changing and Why It Matters', Webpage, 13 August 2018.
[47] Ibid.
[48] Anita Charlesworth and Paul Johnson, *Securing the Future: Funding Health and Social Care to the 2030s* (Institute for Fiscal Studies and The Health Foundation, 2018).

Figure 6: Age profile of UK public spending on health



Source: OBR, *Fiscal Sustainability Report: July 2018,* 2018

Alongside increasing expenditure on health, ageing drives increasing demand for social care services. The number of disabled older people (those unable to perform at least one instrumental activity of daily living) will increase by 67 per cent by 2040 and by 116 per cent by 2070.[49] In turn, public expenditure on social services for older people is projected to more than double, from around £7.2 billion in 2015, to £18.7 billion in 2040.[50]

Though ageing is associated with a range of health conditions and co-morbidities (see below), it is a particular driver of neurodegenerative conditions such as Alzheimer's and dementia which result in significant ongoing costs. The number of older people living with dementia in England is expected to almost double between 2019 and 2040 – from 748,000 to 1,352,400.[51] In turn, the health and social care costs associated with dementia are expected to double and triple respectively in this same period.[52]

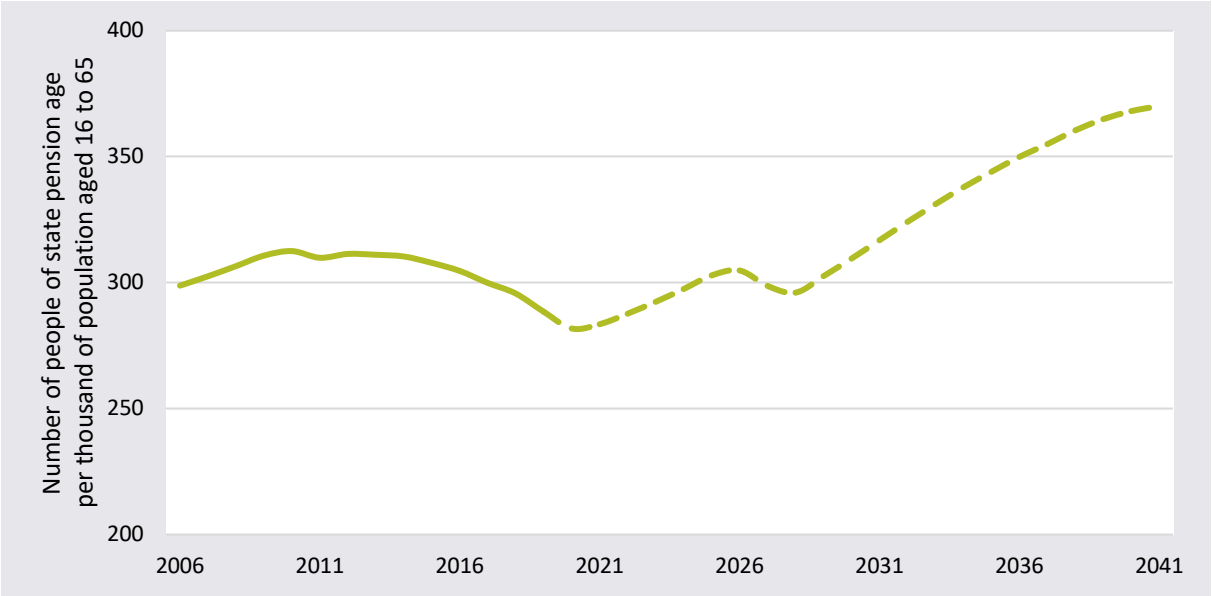
Ageing will drive up the cost of providing care, but we should also consider its implications for the revenue needed to finance it. In a system that is mainly financed through taxes on the working-age population (National Insurance and Income Tax), population ageing will mean that a smaller tax base exists to fund care.

The old age dependency ratio (OADR) is the most common way to represent this and measures the ratio between those over state pension age and those of working age. Figure

[49] Raphael Wittenberg, Bo Hu, and Ruth Hancock, *Projections of Demand and Expenditure on Adult Social Care 2015 to 2040* (Personal Social Services Research Unit, 2018).
[50] Ibid.
[51] Raphael Wittenberg et al., *Projections of Older People with Dementia and Costs of Dementia Care in the United Kingdom, 2019–2040* (Care Policy and Evaluation Centre, London School of Economics and Political Science, 2019).
[52] Ibid.

7 shows the projected increase in the old age dependency ratio over time. Clearly, with demand rising, care costs increasing and a smaller tax base to pay for services, an honest conversation about how to fund the system is necessary (see Section 5.3)

Figure 7: Old age dependency ratio, projected to 2040



Source: ONS, *Living longer and old-age dependency – what does the future hold?,* 2019

2.2 CHRONIC CONDITIONS AND MULTIMORBIDITY

Alongside the fact that the population is getting older, more of us are living with chronic long-term conditions. For much of the population, managing more than one such condition has become the norm.

It is a significant achievement of our health system that many of us are able to live for longer with conditions that were once untreatable. But the prevalence of chronic conditions and multimorbidity also poses a significant challenge.

Chronic conditions and multimorbidity dominate health service use and expenditure. When comprehensive data on long-term conditions and multimorbidity was last collected a decade ago, it was found that those living with long-term conditions account for 50 per cent of GP appointments, 64 per cent of outpatient appointments and 70 per cent of inpatient bed days.[53] 70 per cent of total health and care spend in England goes towards this group.[54]

The cost of providing care for those living with chronic conditions is likely to continue increasing. More than a quarter of adults in England, over 14 million people, already have

[53] Department of Health, *Long Term Conditions Compendium of Information: Third Edition*, 2012.
[54] Ibid.

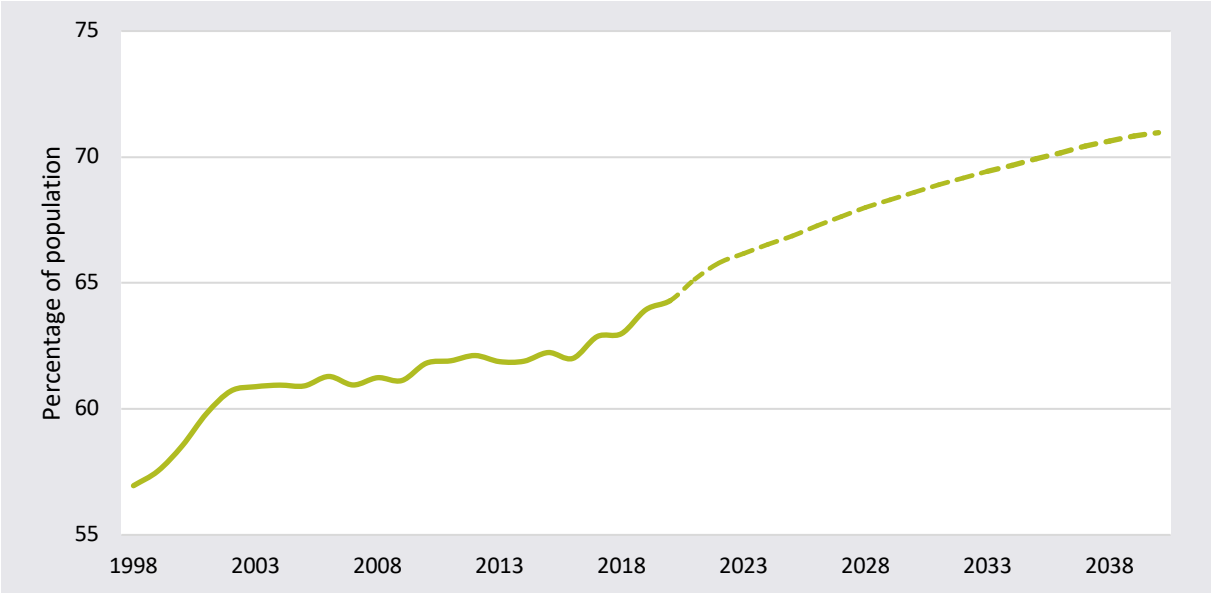
two or more health conditions.[55] Importantly, given the close association between chronic conditions and ageing, we can expect this number to increase. Those living into old age are far more likely to suffer from co-morbid conditions such as chronic pain, diabetes, and hypertension and by 2035, approximately 68 per cent of over 65s will have two or more long-term conditions, up from 54 per cent in 2015.[56]

Although multimorbidity is more common in older people, the number of working-age and young people living with chronic conditions and multimorbidity has also increased in recent years.[57] Working-age multimorbidity is closely related to inequality – multimorbidity occurs on average 10 to 15 years earlier for people living in the most deprived areas of the UK compared with the most affluent.[58]

The causes of increased chronic conditions and multimorbidity are complex: from increased survival rates due to improved treatment, to increased detection of conditions. However, much of the increased burden of chronic disease relates to poor underlying population health. In recent decades there has been a huge rise in the proportion of people classified overweight or obese, and the majority of adults in England are now overweight or obese.[59] The rate of obesity has almost doubled since 1993.[60] Perhaps most stark, 20 per cent of year six children are obese.[61]

[55] National Institute for Health and Care Research, 'Multiple Long-Term Conditions (Multimorbidity): Making Sense of the Evidence', Webpage, 30 March 2021.
[56] National Institute for Health and Care Research, 'Multi-Morbidity Predicted to Increase in the UK over the next 20 Years', Webpage, 20 March 2018.
[57] Ibid.
[58] Karen Barnett et al., 'Epidemiology of Multimorbidity and Implications for Health Care, Research, and Medical Education: A Cross-Sectional Study', *Lancet* 380, no. 9836 (7 July 2012): 37–43.
[59] NHS Digital, *Statistics on Obesity, Physical Activity and Diet, England 2021*, 2021.
[60] Carl Baker, *Obesity Statistics* (House of Commons Library, 2022).
[61] Office for Health Improvement and Disparities, *Year 6: Prevalence of Obesity (Including Severe Obesity)*, 2021.

Figure 8: Adults overweight or obese (three-year rolling average), projected to 2040



Source: NHS Digital, *Health Survey for England 2019,* 2019; Cancer Research UK, *Overweight and obesity prevalence projections for the UK, England, Scotland, Wales and Northern Ireland, based on data to 2019/2020,* 2022; Graph begins with NHS Digital data, using Cancer Research UK data to project to 2040

Obesity is strongly associated with a range of preventable health conditions – several types of cancer, cardiovascular disease, hypertension and stroke. Obesity has driven particularly large increases in Type 2 diabetes. The cost of diabetes-related treatment and complications is estimated at over £14 billion and is expected to account for 17 per cent of the NHS's entire budget by 2035.[62] Further, the prevalence of diabetes among young people is increasing. In 2019, there were 745 under 25s receiving care for Type 2 diabetes in England and Wales – a condition usually only seen in over 40s – a 47 per cent increase on 2014 (for comparison, the population of under 25s increased by less than two per cent over the same period).[63]

Our mental health is also steadily deteriorating. The proportion of people experiencing common mental health problems has increased by around a fifth since the early 1990s.[64] In England, one in four of us will experience a mental health problem each year,[65] while one in six of us report experiencing a common mental health problem in any given week.[66] And, again, prevalence among young people is significant and worsening: in 2020, one in six

[62] Nick Hex et al., 'Estimating the Current and Future Costs of Type 1 and Type 2 Diabetes in the UK, Including Direct Health Costs and Indirect Societal and Productivity Costs', *Diabetic Medicine* 29, no. 7 (July 2012): 855–62.

[63] Local Government Association, 'Obesity Crisis: Type 2 Diabetes in Children up by Nearly Half in Five Years', Press Release, 13 July 2019.

[64] Carl Baker, *Mental Health Statistics in England: Prevalence, Services and Funding* (House of Commons Library, 2018).

[65] NHS England, *The Five Year Forward View for Mental Health: A Report from the Independent Mental Health Taskforce to the NHS in England*, 2016.

[66] Carl Baker, *Mental Health Statistics in England: Prevalence, Services and Funding*.

children aged 5 to 16 were identified as having a probable mental disorder, up from one in nine in 2017.[67]

2.3 INCREASING COST OF CARE

Ageing and increasing chronic condition prevalence do not alone explain the significant cost increases projected in the coming decades. The cost of providing care is also increasing. This is largely for two reasons: the relative ability to increase productivity in health has been lower than in other sectors and innovation has been cost accelerating rather than cost reducing.

As an industry, healthcare has traditionally been dependent on highly trained, professional staff providing personalised services. Like other labour-intensive service industries, increasing productivity in healthcare has proved more difficult than in other sectors, particularly those which produce standardisable goods. However, to recruit and retain workers, pay in the healthcare sector must keep pace with other sectors.[68] This phenomenon, known as 'Baumol's cost disease', means that maintaining health 'output' requires an increasing commitment of resources over time.[69]

While the specificities of the healthcare sector may make productivity increases difficult, we should not regard low productivity and increasing cost as inevitable. Though our health system is regarded as relatively efficient by international standards, we should remain vigilant about unnecessary waste.[70] We should also continue to explore ways to mitigate against the effect of healthcare's 'cost disease', from shifting tasks away from the highest paid professionals to other health workers, developing the capacity for patient self-care, and investing in technology to drive efficiency in areas of the healthcare system that are more easily standardised such as administration and financing. This sort of organisational and process redesign innovation is too often overlooked in favour of more exciting technological innovation.

In fact, while technological innovation has a significant role to play both in boosting productivity and driving better patient outcomes, such innovation has tended to be cost accelerating rather than cost reducing. Even where the unit cost of providing care is reduced, innovation, often in the form of new procedures and treatments, often helps extend or improve the lives of those living with conditions. Patients live for longer, but remain in need of ongoing care, driving up health spending in turn.

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[67] NHS Digital, *Mental Health of Children and Young People in England 2021 - Wave 2 Follow up to the 2017 Survey*, 2021.

[68] William J. Baumol et al., *The Cost Disease: Why Computers Get Cheaper and Health Care Doesn't* (New Haven, Connecticut: Yale University Press, 2012).

[69] Ibid.

[70] Mark Dayan et al., *How Good Is the NHS?*

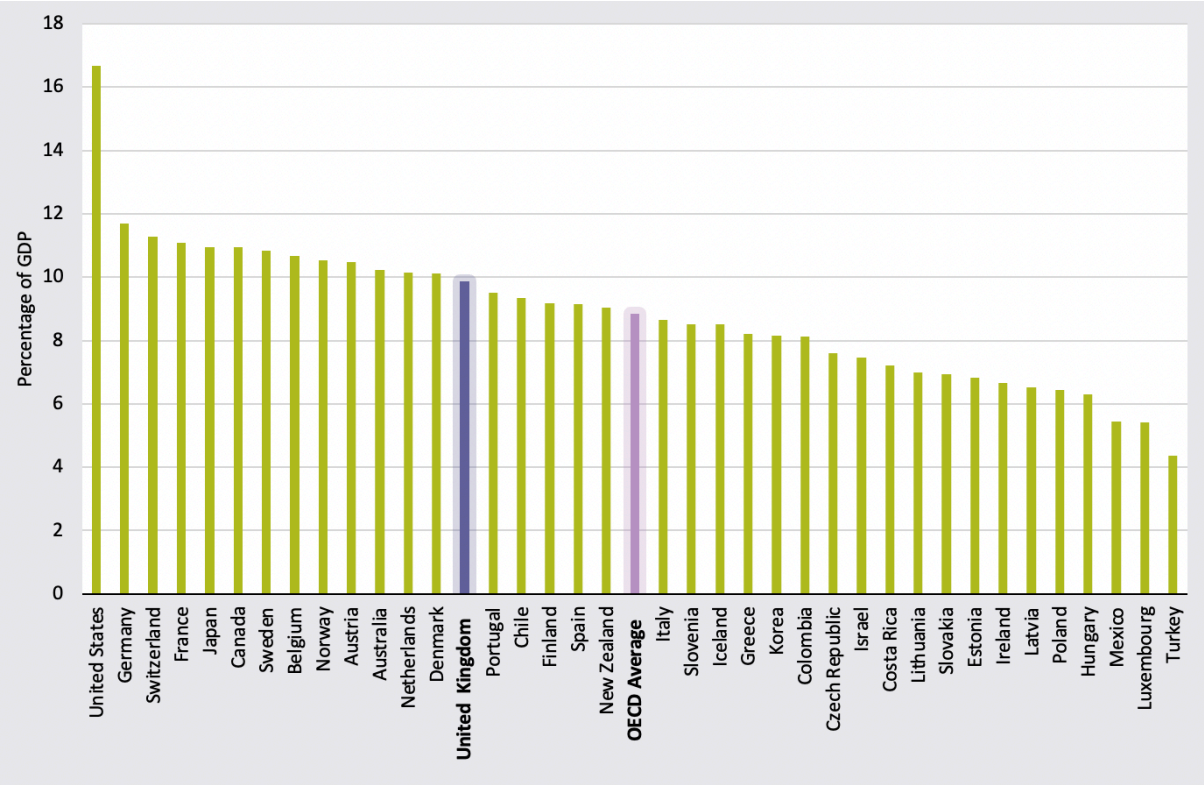
3. EXPLAINING THE DIAGNOSIS: GETTING THE ANSWER RIGHT

Prescribing the right course of treatment for our chronically ill health system requires understanding how it reached its current state. A range of explanations have been offered, and many contain an element of truth, but none on their own can solve the problems we face.

3.1 ARE WE UNDER-SPENDING?

A lack of spending is often seen as the root cause of our health system's problems. The UK spends slightly less on healthcare per capita than comparable countries such as Germany, the Netherlands and France. However, the UK spends more than the OECD average, and more than many countries whose health systems outperform it on the key metrics outlined above – for instance, Italy, Israel, and Australia (see Figure 9).[71]

Figure 9: Healthcare spending of OECD countries (2019)



Source: OECD, *Healthcare expenditure and financing*, 2019

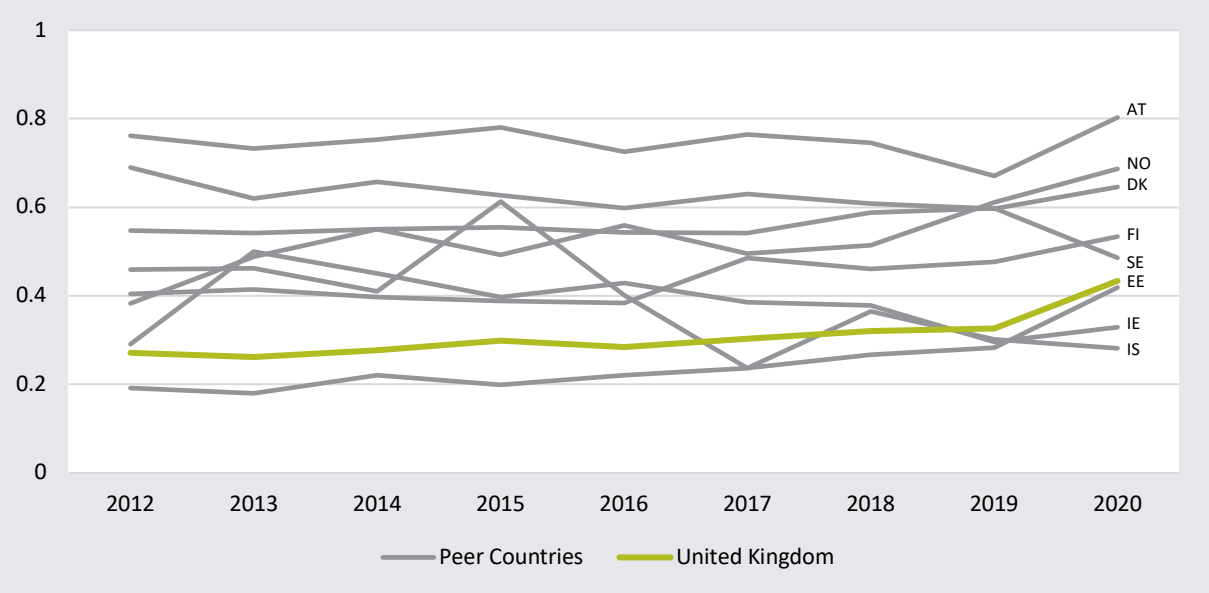
Rather than just looking at total spend, it is important to understand which areas of health spending are lower in the UK than comparator countries. A lack of capital investment stands out as an issue in our health system. This has left the UK lagging the OECD average when it

[71] Organisation for Economic Cooperation and Development, *Health Spending (Indicator)*, 2022.

comes to investment in key equipment such as CT and MRI scanners and struggling with outdated IT systems.[72]

Capital underinvestment has also resulted in a large and rising maintenance backlog needed to restore the NHS estate to a satisfactory, safe condition. According to a 2020 NAO report, large parts of the estate now struggle to "meet the demands of a modern health service".[73] Growth in the "high risk" maintenance backlog – repairs that must be addressed to "prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution"[74] – is especially concerning. Between 2011-12 and 2020-21, the high-risk backlog increased by more than 400 per cent, to £1.57 billion, whilst the total maintenance backlog reached nearly £10 billion.[75] This puts patients at risk of harm, results in worse treatment outcomes, and significantly increases costs in the long run.[76]

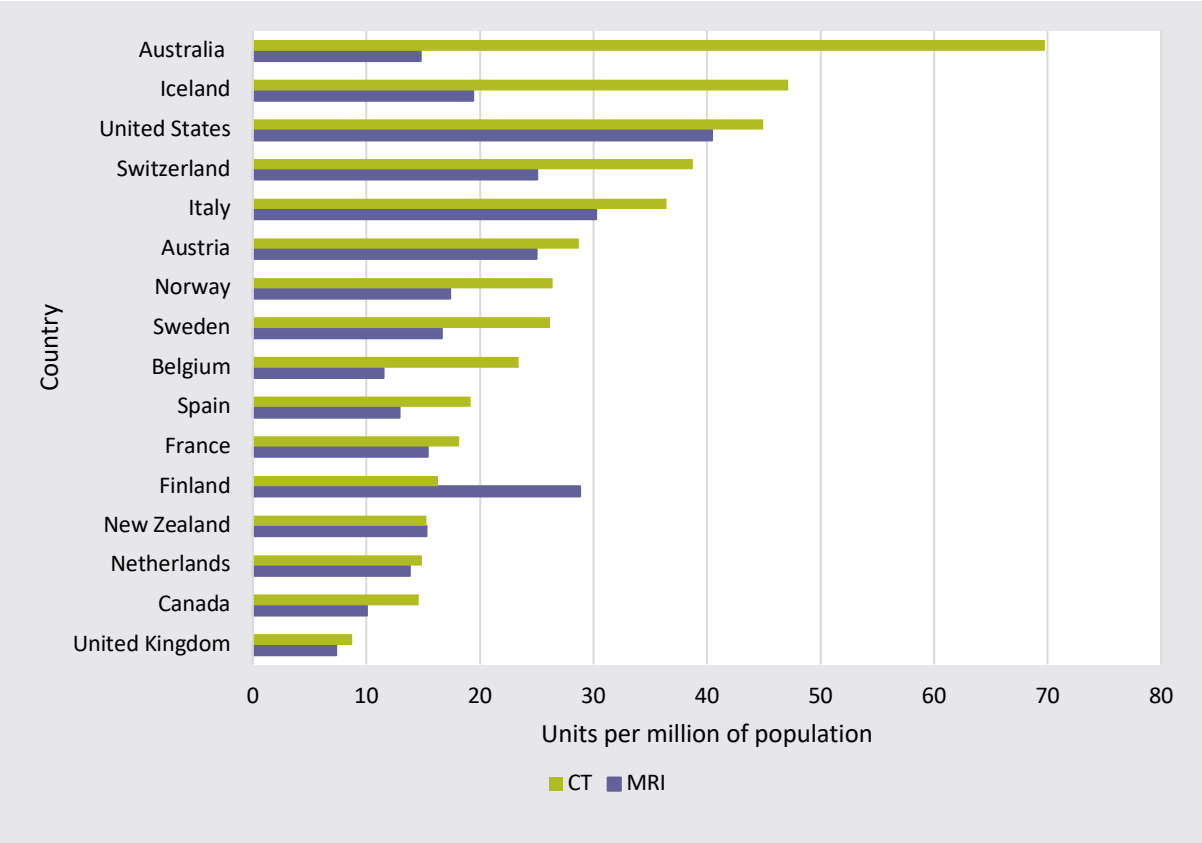
Figure 10: Capital spending on healthcare, UK versus comparator countries



Source: OECD, *Gross Fixed Capital Formation in the healthcare sector as a share of GDP,* 2022; Peer countries: Austria, Denmark, Estonia, Finland, Iceland, Ireland, Norway, and Sweden; chosen based on availability of OECD data

[72] Organisation for Economic Cooperation and Development, *Computed Tomography (CT) Scanners (Indicator)*, 2022.; Organisation for Economic Cooperation and Development, *Magnetic Imaging Resonance (MRI) Units (Indicator)*, 2022.
[73] National Audit Office, *Review of Capital Expenditure in the NHS*, 2020.
[74] NHS Improvement, *Estates Returns Information Collection (ERIC), 2017-18: Approved Fields and Definitions*, 2018.
[75] NHS Digital, *Estates Return Information Collection (ERIC) 2020/21: Data Quality Report 2021*, 2021.; Health & Social Care Information Centre, *Estates Returns Information Collection – ERIC: England 2014-15*, 2015.
[76] National Audit Office, *Review of Capital Expenditure in the NHS*.

Figure 11: Availability of health equipment

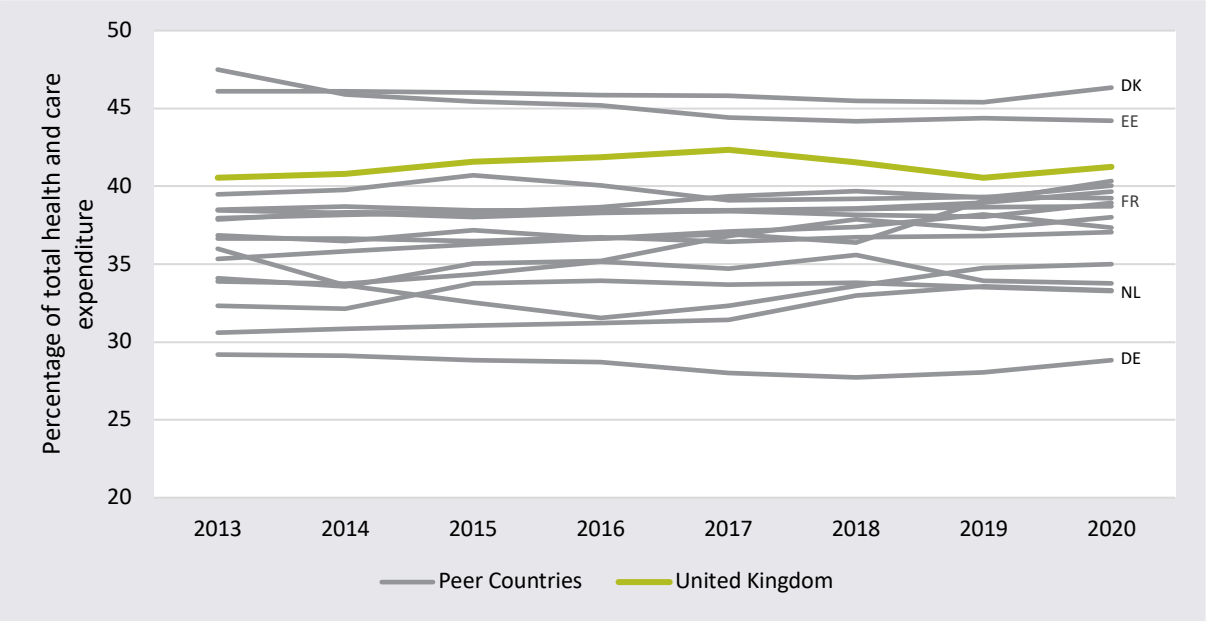


Source: OECD, *Magnetic Resonance Imaging (MRI) units, Computed tomography (CT) scanners*, 2019; Ashcroft, M. & Oakeshott, I., *Life Support*, 2022; Countries chosen based on availability of OECD data; CT and MRI data for the UK as cited in *Life Support*

Crucially, the UK spends more than most comparator countries on hospitals and the acute sector (see Figure 12). With prevention and a greater role for primary care a clear priority across advanced health systems, ongoing dominance of hospital trusts within the NHS raises questions about where money is best spent.

Given that treatment for people with long-term conditions will comprise an ever-greater share of the health system's work, moving care into the most appropriate setting, often closer to home and in communities, will be crucial to the performance of health and social care. This is clearly not yet happening and further, as Section 4.1 shows, the trend of the last five years has been towards a greater proportion of NHS spending on hospitals.

Figure 12: Spending on hospitals, UK versus comparator countries



Source: OECD, *Current expenditure on health (all functions), by hospital providers,* 2022; Peer countries: Austria, Belgium, Denmark, Estonia, Finland, France, Germany, Iceland, Ireland, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Sweden, and Switzerland; Chosen based on availability of OECD data

Improving population health means looking beyond healthcare spending to the wider determinants of health. But we must still ask whether, within healthcare budgets, money is being allocated in a way that optimises outcomes. As health and care budgets have continued to grow, budgets directed at prevention (such as public health spending by local government) have remained static,[77] whilst in key areas from obesity and smoking reduction to sexual health, budgets have declined.[78] This is despite public health spending being shown to decrease years of expected mortality for a quarter of the cost of healthcare spending.[79]

3.2 ARE WE UNDER-STAFFED?

One of the most common arguments used to explain our poor performance concerns numbers of staff in our health system. The number of practicing doctors (3.0 per 1,000 population) and nurses (8.45 per 1,000 population) in the UK is slightly lower than the OECD average (3.5 and 8.8 respectively).[80]

[77] Office for National Statistics, 'Healthcare Expenditure, UK Health Accounts: 2020', Webpage, 9 May 2022.
[78] David Finch, Louise Marshall, and Sabrina Bunbury, 'Why Greater Investment in the Public Health Grant Should Be a Priority', *The Health Foundation*, 5 October 2021.
[79] Stephen Martin, James Lomas, and Karl Claxton, 'Is an Ounce of Prevention Worth a Pound of Cure? A Cross-Sectional Study of the Impact of English Public Health Grant on Mortality and Morbidity', *BMJ Open* 10, no. 10 (October 2010).
[80] Organisation for Economic Cooperation and Development, *Number of Medical Doctors and Nurses*, 2021.

However, these numbers must be treated with some caution. Many roles performed by doctors and nurses in the OECD are performed by allied health professionals in the UK.[81] Our total health and social care workforce is – per capita – among the largest in the OECD (and larger than countries like Austria and Ireland, that achieve better health outcomes).[82] Important as they are, citing only doctors and nurse numbers therefore underestimates the country's health workforce.[83]

Further, the link between doctor and nurse numbers and performance is not clear. Though some high-performing health systems have a significantly higher number of doctors and nurses per capita, many achieve better healthcare outcomes than the UK with a lower ratio – of fewer than three doctors per thousand inhabitants (e.g., Japan, South Korea, and Canada) – or with a similar ratio (e.g. Israel, France, and New Zealand).[84]

Finally, as with spend, it is important to look beyond headline figures. Rather than looking at staffing numbers in total, we should consider where staff are located in the system. In the case of medical personnel, it is important to consider the split between largely hospital-based specialists and community-based generalists. To deal with the challenges of an ageing population with an increasing level of multimorbidity, the NHS has pledged to increase numbers of generalist staff and community health practitioners. However, over the last decade, the number of hospital consultants has increased by 45 per cent,[85] while the number of GPs has remained flat (see Section 4.1).[86] Despite significant growth in demand for adult social care over the last decade, the workforce in this area has only increased by 12 per cent since 2012-13.[87]

Similarly, a fixation on the number of frontline medical and care personnel overlooks the fact that delivering quality care is reliant on a range of auxiliary staff including managers and administrators. The complexities of modern health systems require excellent capabilities in operational management, not least to ensure that high-skilled clinical staff are using their expertise and spending their time most effectively. Despite the operational challenges our health system faces, the number of managers in the system relative to frontline staff has been in decline,[88] and contrary to popular perception, managers make up only 2 per cent of the NHS workforce compared to 9.5 per cent of the UK workforce as a whole.[89]

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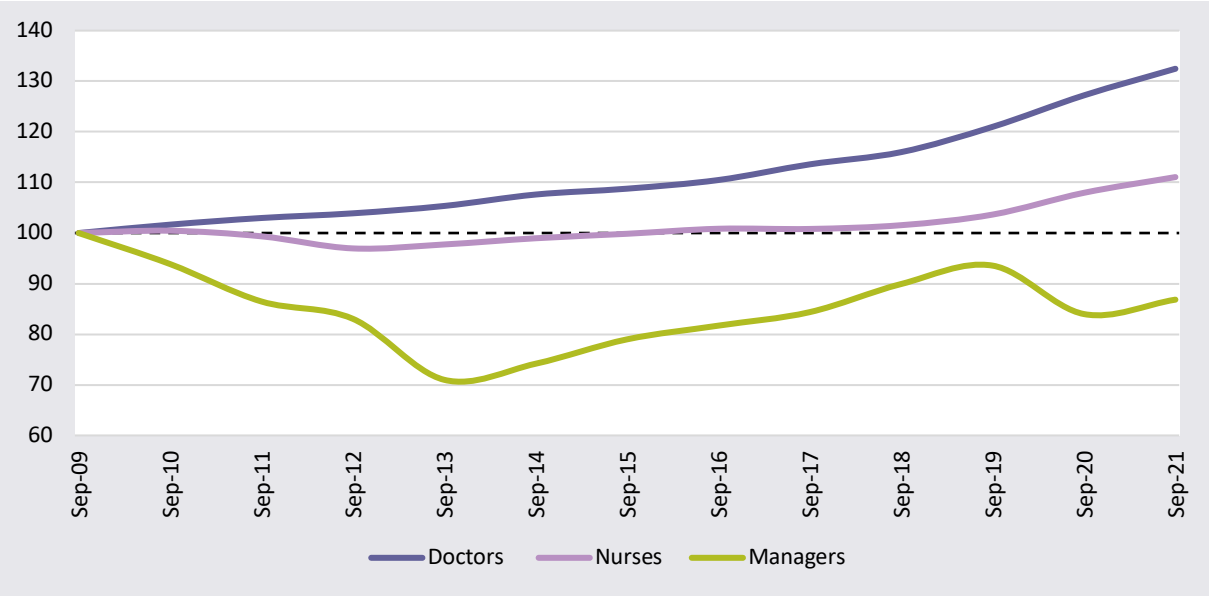
[81] NHS England, 'Allied Health Professionals', Webpage, 2022.
[82] OECD, *Health Care Resources: Total Health and Social Employment*, 2022.
[83] Billy Palmer, 'Is the Number of GPs Falling across the UK?', *Nuffield Trust*, 8 May 2019.
[84] Organisation for Economic Cooperation and Development, *Doctors (Indicator)*, 2022.
[85] NHS Digital, *NHS Workforce Statistics, England and Organisation: April 2022*, 2022.
[86] NHS Digital, *General Practice Workforce: June 2022*, 2022.
[87] Skills for Care, *The State of the Adult Social Care Sector and Workforce in England*, 2021.
[88] NHS Digital, *NHS Workforce Statistics, England and Organisation: April 2022*.
[89] Ian Kirkpatrick and Becky Malby, 'Is the NHS Overmanaged?', *NHS Confederation*, 24 January 2022.

Figure 13: Decline in number of NHS managers (100 = 2009 level)



Source: NHS Digital, *NHS Workforce Statistics, England and Organisation: April 2022*, 2022; NHS Digital, *NHS Workforce Statistics, Staff Group, Care Setting and Level: April 2022*, 2022

3.3 ARE WE UNDER-PAYING?

Alongside medical staff numbers, pay is often pointed to as a reason for declining performance. The argument is that retaining medical professionals in the public sector and maintaining motivation among staff has become more difficult in a period of stagnant pay.

It is certainly true that real terms pay in the NHS remains below its 2010 level and key groups of healthcare staff including hospital consultants, foundation doctors and specialty doctors have experienced real terms pay cuts in the last decade.[90]

However, UK doctors earn more than three times the national average wage,[91] a figure which is high in comparison to other OECD countries.[92] Additionally, those working in the NHS receive pension packages that are more generous, on average, than those in the private sector.[93]

NHS consultants earn between £84,559 and £114,009 depending on experience, which can increase further with bonus pay,[94] and be supplemented by working in private practice outside of NHS contracted hours – which, based on a 2011 estimate, as many as half of all

[90] Ben Zaranko, 'Pay Compression in the NHS (and Beyond)', *Institute for Fiscal Studies*, 1 June 2022.
[91] NHS Digital, *GP Earnings and Expenses Estimates*, 2021.
[92] Organisation for Economic Cooperation and Development, 'Remuneration of Doctors (General Practitioners and Specialists)', Webpage, 2019.
[93] Department of Health and Social Care, 'NHS Pension Scheme: Proposed Changes to Member Contributions from 1 April 2022', Webpage, 15 February 2022.
[94] British Medical Association, 'Pay Scales for Consultants in England', Webpage, 1 July 2022.

NHS consultants are thought to do.[95] At the lower paid end, this puts NHS consultants in the top 5 per cent of earners pre-tax, and at the higher end, they belong to the top 1 per cent of earners.[96] The average GP salary is £100,700.[97]

More attention should be given to the lower-paid end of the health and care labour market. Although the long-run earnings potential of junior doctors (Foundation Years) is high, there are legitimate questions about the adequacy of starting pay levels for this group. Given the duration of their training and the significant responsibilities they have for providing patient care, a starting salary of £29,384[98] – lower than the Government's committed £30,000 salary for newly qualified teachers[99] – appears low. Real terms cuts to pay over the past decade will be felt more severely among lower paid health workers.

Nurses are another case in point, earning slightly below the OECD average, both in total terms and as a ratio of the median wage,[100] and the average pay of nurses is around 5 per cent less than a decade ago.[101]

The pay situation is most acute among social care workers. Despite pay increases as a result of the introduction of the National Living Wage in 2016, low pay remains the norm.[102] The rate of pay increases in social care has failed to keep up with pay increases in other lower-paid sections of the labour market. Average care worker pay is now lower than pay for cleaners and sales and retail assistants.[103] Additionally, pay and career progression are limited in adult social care – care workers with five or more years' experience can expect to be paid only 6p more per hour than those with less than a year of experience.[104]

However, while pay is one factor which affects recruitment, retention and performance, poor institutional culture and conditions clearly matter too, and are a particular cause for concern in our health and care system. According to the most recent NHS staff survey, less than 60 per cent of NHS staff would recommend their organisation as a place to work, almost 50 per cent had felt unwell as a result of work-related stress, and around one in five staff members

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[95] *Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants: Population Overview Report for the Office of Fair Trading* (GHK Consulting Ltd. and Office of Fair Trading, 2011).; The most recent official survey on the number of privately practising NHS Consultants is from 1992, and so more up-to-date data relies on estimation.

[96] HM Revenue and Customs, *Percentile Points from 1 to 99 for Total Income before and after Tax*, 2022.

[97] NHS Digital, *GP Earnings and Expenses Estimates 2019/20*, 2021.

[98] British Medical Association, 'Pay Scales for Junior Doctors in England', Webpage, 18 August 2022.

[99] School Teachers' Review Body, *Thirty-Second Report - 2022*, 2022.

[100] Organisation for Economic Cooperation and Development, 'Remuneration of Nurses', Webpage, 2021.

[101] Nihar Shembavnekar, 'How Has NHS Staff Pay Changed over the Past Decade?', *The Health Foundation*, 20 July 2021.

[102] The King's Fund, 'Social Care 360: Workforce and Carers', Webpage, 1 March 2022.

[103] Simon Bottery, 'Why You're Better off Being a Cleaner than a Care Worker', *The King's Fund*, 28 October 2019.

[104] *Pay in the Adult Social Care Sector* (Skills for Care, 2022).

had experienced bullying, harassment or abuse from colleagues in the last 12 months.[105] Staff satisfaction is particularly low among nurses, 40 per cent of whom "often" or "always" feel "burnt out" due to their work, and more than a third think about leaving their jobs "often".[106]

3.4 ARE WE FAILING TO INNOVATE?

High-performing health systems invest in innovation to reduce costs and generate better outcomes for patients. The UK has a strong history of medical innovation. The UK remains a world pharmaceuticals and medical technology leader as was clearly demonstrated during the pandemic. We have long been a pioneer of new forms of medical treatment from ultrasound to IVF.

There is, however, a significant issue with NHS uptake of digital innovation, and significant variation in appetite and ability to do so across NHS providers. As a House of Lord's Committee on the long-term sustainability of the NHS noted in 2017, "there is a worrying absence of a credible strategy to encourage the uptake of innovation and technology at scale across the NHS."[107]

Progress made since has been promising: for example, the UK launched the world's largest genomic sequencing project in 2019,[108] and in 2020 created an Accelerated Access Collaborative, to fast-track the adoption of "breakthrough" technology and medicine in the NHS.[109] However, significant barriers still exist, including the difficulty of navigating regional variations in NHS bureaucracy (particularly for SMEs), a lack of opportunities for clinicians themselves to innovate, and health datasets that continue to be fragmented.[110]

In addition, while the pandemic forced the adoption of telehealth, particularly in primary care, there has been limited focus on the potential for technology to transform community, social and mental healthcare. However, it is also worth noting that technological innovation will not be a silver bullet to 'solve' our health conundrum. Many of the most effective health interventions remain low-tech – tackling the drivers of ill-health – and, as already noted, innovation can also be cost accelerating, both by increasing demand for treatment and extending the number of years people spend in ill-health.

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[105] NHS England, *NHS Staff Survey National Results*, 2022.
[106] Ibid.
[107] House of Lords Select Committee on the Long-term Sustainability of the NHS, *The Long-Term Sustainability of the NHS and Adult Social Care, Report of Session 2016-17*, HL Paper 151 (London: The Stationery Office, 2017).
[108] Wellcome Sanger Institute, '500,000 Whole Human Genomes Will Be a Game-Changer for Research into Human Diseases', Press Release, 11 September 2019, 000.
[109] National Institute for Health and Care Excellence, 'Accelerated Access Collaborative (AAC)', Webpage, 2022.
[110] Anmol Arora et al., 'Innovation Pathways in the NHS: An Introductory Review', *Therapeutic Innovation and Regulatory Science* 55, no. 5 (September 2021): 1045–58.

4. TOWARDS A NEW A MODEL OF HEALTH

4.1 BUSINESS AS USUAL WILL PUT US OUT OF BUSINESS

When it comes to solving the challenges our health system faces, including those identified above, the usual answer is to inject more resources into the system. Spending substantially more on healthcare could see doctor numbers increase, more new treatments come online, and improvements to our health and care estate.

However, the scale of spending required to meet the challenges the system faces using our current model of funding and delivery would require unsustainable expenditure. According to estimates by the IFS and Health Foundation, to fund an NHS in its current form which would meet all of its constitutional standards (waitlist lengths and times, emergency admission speed, cancer treatment targets) would require a rise of 4 per cent on average per year.[111] This would bring the total amount spent on the NHS to £249 billion in 2033-4.[112] If public spending as a percentage of GDP remains unchanged, that would require further cuts to non-NHS spending of 10 per cent.[113] Again, that's cuts to services which are key to health creation.

These forecasts of future health funding are substantial, but history suggests we should not expect the health system to live within its means. Comparing funding forecasts for the NHS with actual amounts spent shows that additional cash injections to 'top-up' the health budget are almost always made. On only two occasions since 1982 has health spending grown by less than was originally planned; temporary funding increases almost always become permanent.[114]

Several of the drivers of increasing expenditure in our health system are very difficult to control. Our population will continue to age, and scientific innovation will continue to expand the range of treatments and clinical interventions on offer, increasing costs and prolonging life. If we are to accept higher healthcare costs in the long run, we must have an honest conversation about how to fairly and adequately fund care (see Section 4.3).

But in the case of poor population health and an increasing burden of illness, we should not accept the high cost of failure that currently exists in our system. Rather than just asking how we can afford business as usual, we should consider whether or not this approach is really getting us to the outcome we seek: a healthier nation.

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111 Anita Charlesworth and Paul Johnson, *Securing the Future: Funding Health and Social Care to the 2030s* (Institute for Fiscal Studies and The Health Foundation, 2018).
112 Ibid.
113 Charlesworth and Johnson, *Securing the Future: Funding Health and Social Care to the 2030s*, 2018.
114 Ben Zaranko, 'An Ever-Growing NHS Budget Could Swallow up All of This Week's Tax Rise, Leaving Little for Social Care', *Institute for Fiscal Studies*, 8 September 2021.

4.2 FUNDING HEALTHCARE IS NOT FUNDING HEALTH

Too often, the debate in this country on how to improve the health of the population focuses on the role of the NHS. While access to high-quality healthcare is vital for keeping us healthy, its contribution to overall health outcomes is relatively modest.

It is estimated that healthcare accounts for just 20 per cent of our health outcomes.[115] Decades of public health research, including the seminal Marmot Reviews, stress the importance of tackling the "social determinants of ill health",[116] and give us an in-depth picture of what keeps us healthy.[117]

Strong relationships and communities boost our wellbeing, provide emotional support, and help us cope with sickness and disability.[118] Living in safe, well-maintained, and secure housing alleviates anxiety and prevents illnesses of deprivation which remain all too common. Enjoying stable and fulfilling work provides material security, a sense of purpose, and social connection all of which boost our physical and mental health.[119]

"Redesigning the system to reduce *and* divert*, rather than simply* manage*, demand for health services will create the space to think more innovatively about how to build a health service fit for the future that ensures timely access to high-quality care for those who need it."*

Yet despite the fact that timely access to high-quality care, while vital, is dwarfed by the non-healthcare determinants when it comes to health outcomes, our policy debate still largely focuses on the role of the Department of Health and Social Care and the NHS. Our too narrow focus on what happens in the four walls of our hospitals and GP surgeries means power and resources flow to the providers of medical *treatment* and not the public services and community assets that keep us healthy.

Maximising the health of the nation requires a cross-government and cross-societal approach, and that means a fundamental shift away from seeing health as an NHS problem to solve. In turn, redesigning the system to *reduce* and *divert*, rather than simply *manage*, demand for health services will create the space to think more innovatively about how to build a health service fit for the future that ensures timely access to high-quality care for those who need it.

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[115] Department of Health and Social Care, 'New Office for Health Promotion to Drive Improvement of Nation's Health', Press Release, 29 March 2021.
[116] Michael Marmot, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post-2010* (Institute of Health Equity, 2010).
[117] Goran Dahlgren and Margaret Whitehead, 'The Dahlgren-Whitehead Model of Health Determinants: 30 Years on and Still Chasing Rainbows', *Public Health* 199 (October 2021).
[118] Julianne Holt-Lunstad, Timothy B. Smith, and James B. Layton, 'Social Relationships and Mortality Risk: A Meta-Analytic Review', *PLOS Medicine* 7, no. 7 (July 2010).
[119] Lord Dennis Stevenson and Paul Farmer, *Thriving at Work: The Stevenson/Farmer Review of Mental Health and Employers* (Department for Work and Pensions and Department of Health and Social Care, 2017).

Reducing demand on our health services will ensure that the time and skills of our world-class clinicians can be used most effectively to provide support for those needing medical care. Capacity constraints in our system are in part a product of medically trained staff spending too much time dealing with people presenting with issues that could be better supported by other services, or that they could reasonably self-manage, given the right help; and in part a result of staff leaving due to the frustrations and pressures inherent in the current system.

It will also help ensure patients can access timely, high-quality care without resorting to further, unintentional, rationing. Again, reducing demand by building a healthy population and diverting those with non-medical issues means the system is less clogged and waiting times for care are reduced. In turn, reducing demand for healthcare will help put our health system on a more sustainable financial footing for future generations.

A new approach to health is needed that enables decisions to be made about priorities and investment with a view to maximising the health of the population. That means creating a model which can assess and act on trade-offs, where services are configured based on the broad health needs of the population, and where individuals and communities are incentivised and supported to play a lead role in boosting their health.

The following table provides a high-level view of the shift in approach we believe is needed.

Figure 14: A new approach to health creation

Current approach	New approach
Produces a national conversation focused on healthcare	Produces a national conversation focused on health creation
Is increasingly unaffordable	Is fiscally sustainable
Takes a 'medical first' approach	Thinks holistically about health and its determinants
Reinforces patients as passive recipients of care	Is patient-centred, treating people as co-creators of health
Is hierarchical and 'one-size-fits-all'	Centralises only where necessary and localises wherever possible
Manages demand by rationing care	Intervenes early to prevent demand arising
Fails to take advantage of the power of communities and neighborhoods	Sees communities as vital to health creation and actively seeks to maximise the benefits of community assets
Struggles to facilitate and adopt innovation	Proactively seeks and adopts innovation

4.3 THE BARRIERS TO TRANSFORMATION

Many of the principles listed in the table above would be embraced by those working in health, and indeed the NHS has a longstanding commitment to shifting resources from the reactive to the preventative. In fact, it would not be a stretch to say there is a consensus on the direction reform needs to take.

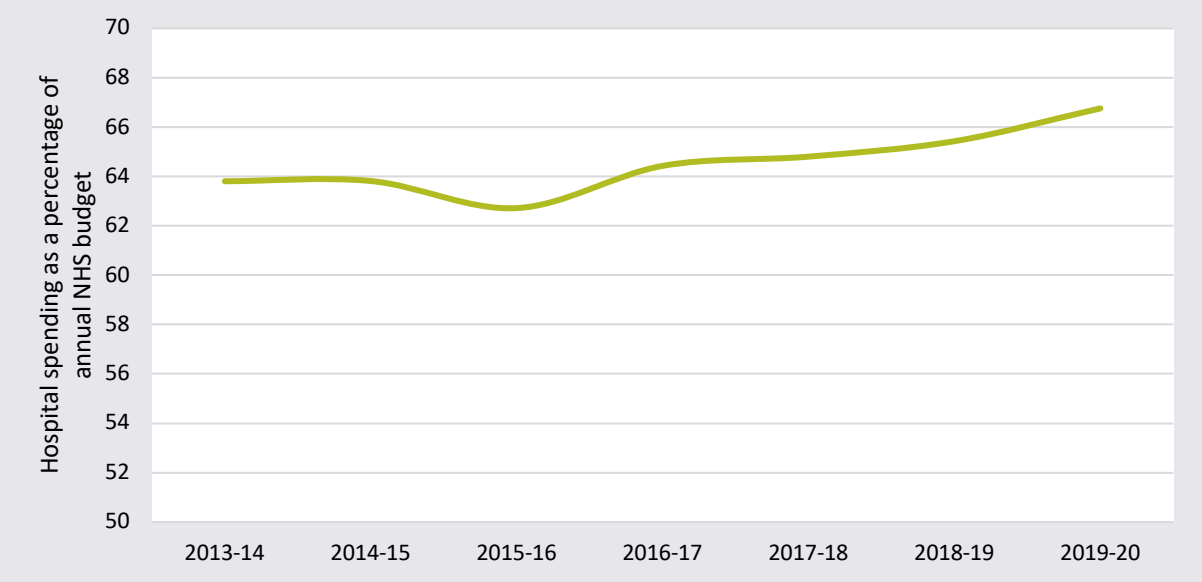
Health secretaries have long stressed the importance of prevention, and the subsequent shift in resources this will take. Both the former Secretary of State for Health and Social Care, Sajid Javid, and his predecessor, Matt Hancock, emphasised the need to transform the NHS from being a "national hospital service" to a "true national health service".[120] Meanwhile their predecessor, Jeremy Hunt, argued that "budgets being ploughed not into NHS acute care but into social and community care – [is] exactly the shift we need to keep people healthy".[121]

In fact, a decade earlier, then Health Secretary Patricia Hewitt published a White Paper in which she pledged that "Year on year, as health and social care budgets continue to rise, we will see more resources invested in prevention and community health and social care than in secondary care."[122]

Yet despite an overt commitment by the NHS itself to "shift from acute to community sector-based working", and "boost out-of-hospital care",[123] this has not materialised. To understand an organisation's priorities, follow the money. Contrary to NHS England's stated ambitions, the proportion of NHS spending on hospitals has actually increased in every year but one since the publication of the 2014 Five Year Forward View.[124]

[120] Department of Health and Social Care and Sajid Javid, 'Health and Social Care Secretary Speech on Health Reform', Webpage, 8 March 2022.; Department of Health and Social Care and Matt Hancock, 'Putting the National, the Health and Service into NHS', Webpage, 27 February 2020.
[121] Department of Health and Social Care and Jeremy Hunt, 'Personal Responsibility', Webpage, 1 July 2015.
[122] Department of Health, *Our Health, Our Care, Our Say: A New Direction for Community Services*, 2006.
[123] NHS England, *The NHS Long Term Plan*, 2019.
[124] National Audit Office, *NHS Financial Management and Sustainability*, 2020.

Figure 15: Growing share of NHS budget spent on hospitals

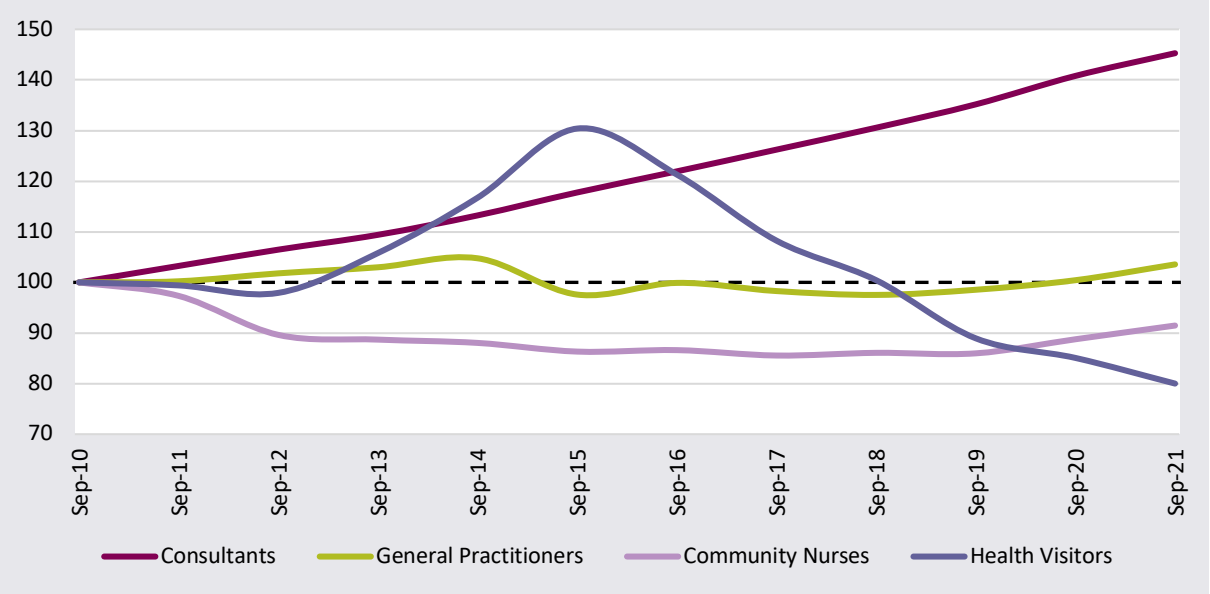


Source: NHS England, *Annual Report & Accounts*, 2013-2020; Hospital spending calculated as the sum of expenditure on foundation trust and "other NHS trust" services, per National Audit Office methodology

On workforce we observe the same pattern. Between 2010-2021, there was an 8.5 per cent decrease in the number of community nurses and a 20 per cent decrease in the number of community health visitors.[125] As we have already noted, while general practitioner numbers stayed constant over the period, the number of hospital consultants grew by 45 per cent.[126] Since the beginning of 2022, the number of hospital consultants has continued to grow, reaching 50 per cent above 2010 numbers in April.[127]

[125] NHS Digital, *NHS Workforce Statistics, England and Organisation: April 2022*.
[126] Ibid.
[127] NHS Digital, *NHS Workforce Statistics, England and Organisation: April 2022*.

Figure 16: Change in full-time equivalent NHS workforce over time (100 = 2010 level)



Source: NHS Digital, *NHS Workforce Statistics, England and Organisation: April 2022*, 2022; NHS Digital, *General Practice Workforce*: *June 2022,* 2022.

4.3.1 NHS and acute provider dominance

Why, then, despite clear aspirations to move towards a model that reduces demand and builds health at home and in our communities, has so little progress been made?

In large part it is because the design of our current system acts against a move away from a sickness service towards a health creating system. As we have seen, resources, and therefore power, are heavily skewed towards the NHS in general and the acute sector specifically.

Several converging factors mean that it is difficult to break this status quo. First, politicians are rewarded by voters for commitments to highly visible policies, often framed in terms of inputs – for instance, promises to train 50,000 new nurses or build 40 new hospitals.[128] An increase in the public health grant, which could result in significant long-run health improvements (but go unnoticed by the electorate) is a less politically compelling investment by comparison. Resisting the temptation to answer to election cycles, rather than pursue long-term outcomes, takes political courage. As does transparently discussing these trade-offs with the public.

Second, decision makers are confronted with a public that often assess the performance of the health system according to metrics such as their access to formal healthcare: long waiting times in A&E, delays to diagnostic scans, or withheld medicines create headlines. Inaction on the drivers of obesity, inadequate housing, or a lack of community infrastructure

[128] Department of Health and Social Care, 'PM Confirms £3.7 Billion for 40 Hospitals in Biggest Hospital Building Programme in a Generation', Press release, 2 October 2020.

– the factors that create and maintain us in good health – usually do not. Decision makers know that they will be held accountable for difficulties patients have in gaining a referral, or for long waiting times for treatment, but not for presiding over deteriorations in population health.

Finally, both public expectations and political decision-making are influenced by powerful interest groups, which tend to be concentrated in the healthcare sector. Powerful professional bodies including the British Medical Association resist change that may challenge the dominance of healthcare providers in the health system.

"In large part the design of our current system acts against a move away from a sickness service towards a health creating service."

Within the healthcare system itself, a status hierarchy sees increasingly specialised consultants dominate[129] – backed up by their royal colleges. Understandably, as special interest groups, they tend to campaign for more resources which, when these resources are finite, equates to greater investment in the acute end of care at the expense of prevention.

It is also the reason that the integrated care system (ICS) reforms will struggle to achieve a fundamental shift. The logic behind Integrated Care Systems – the need to integrate health and social care to support an ageing population living with multiple conditions and build a joined-up, localised approach to health creation – is compelling. In some instances, where strong and visionary leadership exists, creating a more patient-centric, sustainable model of health is already being prioritised.

However, without those individuals, the structure of ICSs and the incentives that exist within them are unlikely to bring about the necessary change in our health system. ICSs are essentially larger scale versions of clinical commissioning groups (CCG). The main function of the Integrated Care Board (ICB) is to allocate NHS funding (just without the requirement to use competitive tendering). They are accountable only to NHS England and the DHSC, from which their budget derives.

Despite the 'integration' branding, local authorities – who have responsibility for public health and social care, as well as many services that directly impact health – are a junior partner at best. ICBs are mandated to include just one local government representative, compared to four healthcare leaders, and just one board out of 42 has a Chief Executive with a local authority background.[130] Though local authorities will be represented within Integrated Care Partnerships (statutory committees within Integrated Care Systems which assess population health needs and help inform ICB commissioning) without direct control over the purse strings, the impact of these partnerships will likely be limited.

[129] Ruth Robertson et al., *Specialists in Out-of-Hospital Settings: Findings from Six Case Studies* (The King's Fund, 2014).
[130] NHS England, 'Integrated Care System Leadership and Websites', Webpage, 2022.

While the Government in its integration white paper makes the case for pooled NHS and social care budgets, there is no requirement to do so. Instead, the paper explicitly states it should be a matter for local areas to decide.[131] This raises questions as to how the new 'integrated place boards', announced in the white paper and to which ICBs and councils are supposed to delegate functions and budgets, will actually work.

In short, despite good intentions, it is unclear that this latest iteration will lead to any real systemic change in behaviour, and therefore outcomes, compared to its CCG and Health and Wellbeing Board predecessor model.

4.3.2 Cascading impacts

The dominance of healthcare providers, and, in particular, the acute sector matters because it has resulted in unintended consequences: a model of health which:

- disempowers citizens;
- underutilises the health creating assets that exist in our communities; and
- limits the value of health innovation.

Firstly, the dominance of health services and acute providers marginalises citizens as co-creators of health: seeking a clinical response as the first port of call when faced with ailments and anxieties remains culturally embedded. We are encouraged to present at a surgery or hospital and the result is that we expect clinicians to step in to 'fix' our health problems, despite the fact that alternative forms of support may be more appropriate.

Secondly, the status of providers and their dominance of the health policy debate means that insufficient focus is given to the hidden health building assets that exist across civil society, in workplaces, and in our neighbourhoods and communities.

Despite a wealth of evidence on the importance of the places we live, socialise and work shaping our health and wellbeing, we too often overlook these settings when it comes to considering how to build a healthy population.[132] Policy makers tend to prioritise the 'formal' institutions that shape our health over the 'informal' networks that often affect our health in more significant ways.

[131] Department of Health and Social Care, *Joining up Care for People, Places and Populations: The Government's Proposals for Health and Care Integration*, 2022.
[132] Public Health England, *PHE Strategy: 2020-25*, 2019.

Building social capital in a community could have a greater impact than building new hospitals or GP surgeries, but the former does not reckon large in policy debate on health. Throughout the country, innovative approaches are being taken to health creation, but these new models remain the exception rather than the norm.[133]

Finally, the priority given to acute health services means that we focus far more o n the potential of technology in these settings than on its role in boosting community health and empowering individuals. Public and community health remain largely digital deserts, yet innovation in these areas could have huge benefits for individuals and the health and care system. A key aim should be to help individuals stay, and become more, healthy, as well as to enable patients to self-manage their care and reduce dependence on formal health settings.

[133] For example, initiatives such as the 'Healthier Fleetwood' programme which has helped launch tens of self-managed community social groups and the Circle movement which creates social connection among older people; see: Mark Spencer, '"Healthier Fleetwood": Creating Healthier Communities via Improved Social Networking in a Disadvantaged Area of the UK', *The British Journal of Diabetes* 17, no. 3 (September 2017).; Hilary Cottam, *Welfare 5.0: Why We Need a Social Revolution and How to Make It Happen* (Institute for Innovation and Public Purpose, University College London, 2020).

5. A WAY FORWARD: *REFORM'S* REIMAGINING HEALTH PROGRAMME

Reforming a complex system is not an easy task. The barriers to overcome in the health system are particularly challenging: strong cultural expectations of what our healthcare system can deliver, powerful and well-respected professional interest groups, and fatigue with re-organisation all make change difficult.

However, *Reform* believes that failing to act means failing citizens, patients and health and care workers. Without fundamental reform, the health – and therefore prosperity – of the nation, along with the NHS itself, will continue to deteriorate.

The experience of the pandemic could not have made the need for change any clearer. The underlying poor health of the nation, and the depth of the demographic and socio-economic health disparities impacting certain communities, meant COVID hit the UK harder than some other countries. The prioritisation of hospitals over care homes – the NHS over social care – led to devastating outcomes for care home residents. The cost of the call to 'protect our NHS' was delayed non-COVID care and deteriorating physical and mental health.

"Failing to act means failing citizens, patients and health and care workers. Without fundamental reform, the health – and therefore prosperity – of the nation, along with the NHS itself, will continue to deteriorate."

The ballooning backlogs, and associated rise in dissatisfaction with the health system (just 36 per cent of people reported being satisfied with the NHS in 2021, a 25-year low),[134] present a real opportunity for an honest debate about the future of health in this country.

This is exactly what *Reform* seeks to do with the *Reimagining Health* programme. The following section outlines the areas we will explore with a view to designing a new approach that would move us from an overburdened sickness system to a sustainable, health creating system. To do this we need to answer three questions:

- How can we maximise the health of the population – what does a health creation model look like?
- Within this, and supporting it, what should the health and care system look like?
- How should this new model be funded?

This framing paper, and the proposed direction of travel outlined below, is the start of our thinking, and we welcome any and all input.

[134] Wellings et al., *Public Satisfaction with the NHS and Social Care in 2021: Results from the British Social Attitudes Survey*.

5.1 UNLOCKING HEALTH CREATION

5.1.1 Shifting the power

Building a sustainable health system requires tackling barriers to change head on. If the key impediment to system change remains where power and resources lie, this is the first barrier that much be addressed.

To this end, a rethink of how funding is distributed is core to reshaping our health system and making trade-offs clearer between investing in healthcare services versus social care or the social determinants of health. Allied to this, a shift is also needed to encourage and enable citizens to play a more proactive role in their health and that of their communities, which includes having a greater say about how decisions are made about health-related funding and services in their area.

In practice, this means a more decentralised system in which the funding of healthcare is not separated from the funding of health creating services. It also means ensuring decisions made about investment priorities and service design are based on the actual needs of local populations – which may well differ from geography to geography. And that means placing decision-making in the hands of those with deep local knowledge.

To achieve this, many of the functions of the Department of Health and Social Care and NHS England may need to be devolved to local leaders and institutions, with clear democratic accountability to the people they serve.

Areas to explore:

- What might radical devolution look like in our health system?
- Given its proximity to communities and responsibility for providing services that create health, what would a health system look like in which local government was put in the driving seat? What capabilities would be required at a local level to make this possible?
- If we were to move to a more decentralised model, what should the role and remit of central government, including the Department of Health and Social Care and NHS England, be?

5.1.2 Activating citizens

If shifting power and resources away from those institutions that treat ill health towards those that create good health is the first pillar of reform efforts, the second must be to empower patients to take more control over their own health. Many patients who live with long-term health conditions wish to have greater control over the management of their conditions, more support to live autonomously, and less dependence on a hierarchical doctor/patient relationship.

But for all citizens, having more ownership over health creation generates better outcomes and reduces dependence on health services.[135] Empowering citizens as health creators is vital to building a sustainable health system.

Areas to explore:

- How can citizens be supported and incentivised to maximise their own health and that of their communities?
- How can patient education be improved to build capabilities in self-care and condition management?
- How can citizen participation be harnessed to inform the design and delivery of health services?
- What should the balance of responsibility be between the State/public services and citizens and communities in building health?
- Is there potential to increase the scope of personal budget programmes to cover those living with long-term conditions?

5.1.3 Harnessing community assets

Empowering individuals is vital, but we should not overlook the powerful role that the places we live, work and socialise play in creating health. A new approach to health would utilise rather than marginalise these assets and make health creation a project shared by public services, businesses and civil society.

Areas to explore:

- How can businesses contribute to health in their communities? How can this role go beyond providing quality employment to provide other forms of resource (space, personnel, skills and knowledge, and access to healthcare) to boost health?
- What role should public services and central and local government play in facilitating businesses' contribution to health?
- What role should government play in supporting community infrastructure (civil society groups, the VCSE sector, social networks) to build health?
- How can physical community assets be better used to support health creation?

5.1.4 Technological transformation

The revolutionary potential of technology to reshape health has long been touted. Yet much of the focus has been on how technology will transform healthcare – for example speeding up access to treatment, and automating surgery and diagnostic. This is vital, but so too is

[135] Judith J. Hibbard and Jessica Greene, 'What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs', *Health Affairs* 32, no. 2 (February 2013).

using technology to enable greater prevention, self-care and community health. The smart use of technology can contribute to demand reduction as well as demand management.

Areas to explore:

- How can public health data can be better collected and utilised to identify at-risk populations, target and evaluate public health interventions, and expand our knowledge on what drives ill health?
- How can other sources of (non-health) data be used to understand and improve community health?
- How can new health technologies (wearable devices, health apps, and digital platforms) be leveraged to provide better public health data and incentivise healthier behaviours?
- How can technology be leveraged to enable people to better understand their own health and self-manage their health needs?
- What role can technology play in transforming social care? How can this help reduce dependence on formal health and care settings?
- Where should the health informatics workforce to most effectively boost population health?

5.2 RETHINKING HEALTHCARE

Reducing demand on our health services through prevention, early intervention and diversion will help alleviate many of its most acute challenges: spiralling costs, overstretched staff and sub-optimal access.

But achieving this will require a rethink of how our health services look and feel. An overly-centralised health system dominated by doctors' surgeries and large hospitals was fit for the mass industrial, 'assembly line' model of treatment it was designed to meet, but is ill-equipped to deal with our current challenges. The sound of a dropped bed pan should not, in fact, be heard in Whitehall – nor should the precise configuration of the health services in any given locality be the business of the Health Secretary.

A serious conversation is needed about the role the centre should play in health services. 14,597 people work in NHS England and the Department for Health and Social Care (not including agency staff, specialist contractors, and so on): an 81 per cent increase since 2014.[136] We need to ask ourselves what actually needs to sit in a central government department or body – for example provision for very rare diseases or health security monitoring – and what would be better delivered on a regional or local level. How far should the centre simply set priorities and standards and hold local areas accountable for delivery against these?

[136] Department of Health and Social Care, *DHSC: Workforce Management Information June 2022*, 2022.

We must also reflect on the role of the independent sector, including not-for-profit organisations, who can and do provide valued healthcare services – and may be better placed to serve marginalised or low-trust communities. While there are examples of meaningful cross-sector partnerships, within the NHS there has been a culture of distrust of non-NHS providers, and current reforms risk excluding them further. In turn, this also risks exacerbating inequalities.

In terms of delivery, it is essential that we move away from our current model of pouring more resources into a hospital-dominated system – care can and should be provided much closer to home, and, where possible, be flexible and personalised to meet people's needs. This should all be considered in the context of the questions raised in Section 4.3.1 about the balance of power and resources.

This is a big political challenge and requires a shift in public expectations. Achieving this shift means reframing the national conversation to enable a genuine and honest engagement with the trade-offs and opportunities.

5.2.1 Primary Care

Primary healthcare constitutes most people's first point of access to the wider health system. But the standard operating model of the GP surgery is in need of a rethink. GPs are increasingly expected to deal with a raft of problems that do not require clinical intervention, or which would benefit from a more holistic, community-oriented approach. In short, problems that should be diverted to a more appropriate setting.

Some progress has been made in encouraging primary care clinicians to take a more holistic approach to health. However, initiatives such as social prescribing, where patients are directed by clinicians to community-based activities such as exercising or joining a local club, may reinforce the idea that medical professionals can solve every problem. The GP surgery should not be the first port of call for those requiring holistic, non-medical support.

Areas to explore:

- How can we change the 'front door' of our health system to ensure that people's needs are met in the most appropriate setting as early as possible?
- Should GP surgeries be replaced by a 'community wellbeing hub' model, where seeing a qualified doctor is one option among many available? What is the role of community or voluntary sector organisations in this?
- Should primary healthcare be co-located with other services such as housing and employment support, family advice and counselling?
- How can we provide holistic health services more effectively outside of bricks and mortar health settings (i.e. in people's homes, neighbourhoods and other community facilities)?

5.2.2 Secondary Care

A mark of high-performing health systems is their ability to prevent patients from requiring high intensity, secondary care. As this paper has argued, for patients with long-term conditions (the bulk of the caseload in the NHS), management in primary and community settings is both more cost-effective and better for patient outcomes. Nonetheless, no matter how good a health system is at demand diversion and reduction, there will always be a need for high-quality, timely specialist care.

Too often in the secondary system, patients find themselves bounced around between specialists, waiting long periods for treatment, and reliant on frequent hospital attendances – often located some distance from them – to get the care they need. Many patients also find themselves trapped in secondary settings due to the fact that interactions between primary and secondary care are inadequate. These experiences are particularly prominent for patients who are already the most marginalised. Those with disabilities, living in poverty, with English as a second language, or lacking in knowledge about care options – are most likely to find themselves unable to access timely support.[137]

Moving more specialist care, diagnostics and emergency care out of large hospitals and into communities is vital for providing more timely, efficient, and higher quality care. It is also more befitting a population often presenting with conditions linked to chronic and co-morbidities.

Areas to explore:

- What services could be effectively moved out of larger hospitals and into the community?
- Is it time to revisit the 'polyclinic' model that has been proposed in the past? And if so, what size population should they serve?
- How should the acute sector be configured to ensure the highest quality care possible for patients?
- How can we ensure that care quality, not just activity is rewarded in the acute sector?
- How does the workforce model need to change to drive more activity outside of a hospital setting?

5.3 FUTURE PROOFING HEALTH FINANCES

Reducing demand and changing the way care is organised and delivered are the two most important levers available for reducing the cost of the healthcare system. But demographic change, particularly population ageing, and other cost pressures (largely driven by advances in pharmaceuticals, medical procedures and technology) will continue to drive up costs, and therefore place considerable strain on the public finances.

[137] NHS England, *Improving Access for All: Reducing Inequalities in Access to General Practice Services*, 2017.

An honest conversation is therefore needed not just about the cost of healthcare, but *how* that cost is met – i.e. the funding model. However, so far discussion in this area has been limited. Where it does occur, we are presented with a false, binary choice between the single-payer, free at the point of use system in the UK with the private insurance dominated model of healthcare in the United States. This fails to acknowledge that there are a variety of different models of financing care internationally. Given the high costs of healthcare in America, and the relatively poor outcomes it generates, it is unclear why those looking to design a new settlement would consider the American approach. However, we can and should be open to exploring how different systems provide equitable access to high-quality care using different financial models.

The financial circumstances in which we find ourselves make exploring alternative funding mechanisms essential. In our current system paying for rising costs, as we have already seen over the past decade, means reducing spending elsewhere, hiking taxes, and/or increasing borrowing. This raises important questions not just about fiscal sustainability, but also intergenerational fairness.

The current approach to health tends to favour older people. An elderly person is far more likely to receive timely care for a fragility fracture resulting from a fall than a young person is to receive timely care for a moderate, yet debilitating, mental health problem.

This intergenerational unfairness is set to get worse. As we have seen, the old age dependency ratio is increasing,[138] meaning the working-age population faces a rising tax burden to sustain public services. This should be seen in the context of the current tax burden, which after the April 2022 National Insurance rise will reach its highest sustained level in peacetime.[139] On current trajectories, future generations also face unsustainable levels of public sector debt – with policy remaining as it stands today, public sector net debt will exceed 300 per cent of GDP by 2071-72.[140] Clearly, policy has to change.

All of this points to the need to have an honest conversation about what we want the heath service of the future to look like and how it will be paid for.

We already have a two-tier system, exacerbated by the pandemic, in which those who can afford to pay for timely healthcare do so: the value of the self-pay healthcare market has doubled since 2010.[141] As waiting lists have rocketed during the pandemic, private providers have reported huge increases in pay-as-you-go demand. Wealthier people are opting out of

[138] Office for National Statistics, 'Living Longer and Old-Age Dependency – What Does the Future Hold?', Webpage, 24 June 2019.
[139] Institute for Fiscal Studies, 'Despite Planning Biggest Tax Rises in More than 25 Years, and an Historic Increase in Size of the State, the Chancellor Is Still Likely to Have Little Money for Hard-Pressed Public Services', Press Release, 12 October 2021.
[140] Office for Budget Responsibility, *Fiscal Risks and Sustainability: July 2022*, 2022.
[141] Chris Thomas, 'The Buy-out Is the Existential Threat to the NHS', *Health Services Journal*, 24 January 2022.

the NHS while the unintended rationing of NHS healthcare (i.e. the inability of the system to meet demand) is hitting the poorest.

Since 1951, means-testing has been in place for optometry and dental services. NICE already makes value for money judgements about medicine and treatments, refusing to provide certain costly interventions on the NHS. Those in need of social care services have always been expected to contribute to their care if they can afford to, even though such needs are as predictable as ageing-related health needs.

"We already have a two-tier system, exacerbated by the pandemic, in which those who can afford to pay for timely healthcare do so."

The latter is an incomprehensible distinction. And on top of this, younger generations may be more willing to pay for health and wellbeing related services and products, especially those which are digitally-enabled. A YouGov poll this year found that 29 per cent of 18 to 34-year-olds say they would consider funding care with their own resources.[142] Expectations may well be changing, we should at least be prepared to have a conversation.

Areas to explore:

- Is there a case for fiscal devolution to help fund local health priorities?
- Would insurance models or pre-payment models for financing long-term care (including healthcare) be more equitable and sustainable?
- Are there more innovative models that could harness new payment habits, for example subscriptions?
- Is there potential for low-cost supplementary insurance models to supplement core services, as are used in other countries?
- What role should occupational health insurance play, and could employers be incentivised to provide cover?

CONCLUSION: A MOMENT FOR CHANGE

This framing document has sought to lay out the ways in which our current approach to health is no longer fit for purpose. There has long been consensus on the change of direction we need: a move away from a system that treats sickness to one focused on truly creating health; a distribution of power and resources to local actors who are best placed to understand the health challenges of their community; and a focus on managing care needs in homes and communities, not in hospitals. But despite agreement on the vision, limited progress has been made, with power and resources remaining disproportionately concentrated in the acute sector.

Reform wishes to explore *how* to achieve this much needed shift. In Sections 4 and 5 of this paper, we have outlined a number of areas we wish to explore over the coming months. We

[142] Kat Lay, 'Young People Willing to Pay for Healthcare as NHS Waiting Lists Grow', *The Times*, 11 April 2022.

do not have the answers yet, and are committed to developing and testing our thinking with those who are already thinking deeply about these questions. If you are a practitioner, policy maker, or systems innovator with big ideas for solving these challenges, we want to hear from you. As we have said: failing to act means failing citizens, patients and health and care workers. Please get in touch and help us reimagine health for the modern world.

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