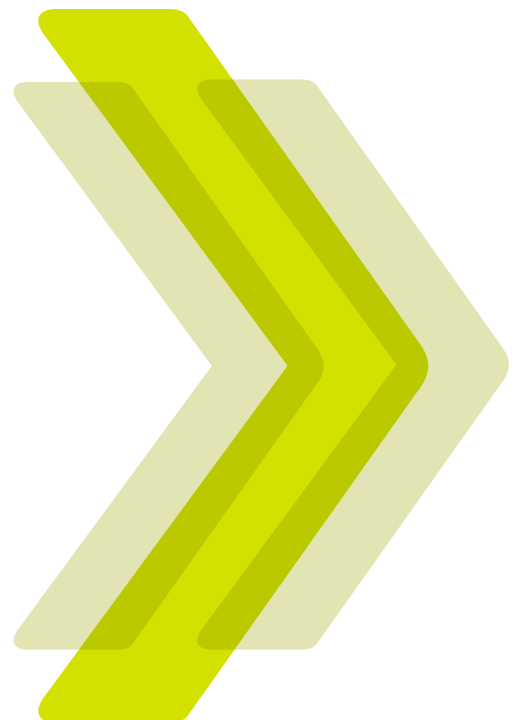


# **The rise and decline of the NHS in England 2000-20**

**How political failure led to the  
crisis in the NHS and social care**

**Chris Ham**

**April 2023**



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# Foreword

The NHS has just come through its most difficult winter in living memory – difficult for both staff and for the patients that rely on it. Perhaps unsurprisingly, these undoubted challenges have led some to question the fundamentals of the NHS. This is why this report is so timely; rather than attributing the current situation to some inevitable built-in decay, it draws out the decisions (or lack of them) that have led to the current crisis. It is to be hoped that it will also help us avoid making the same mistakes again, should a mix of reform and investment enable the same scale of recovery we saw through the decade following 2000.

This report is the personal work of Chris Ham, who as many of you will know, was Chief Executive of The King's Fund through much of the decade in question. This has provided him with a unique insight into these years and we thank him for this report.

**Richard Murray**  
Chief Executive  
The King's Fund

# Key messages

## The story of decline

- Multi-year funding increases above the long-term average and a series of reforms resulted in major improvements in NHS performance between 2000 and 2010.
- Performance has declined since 2010 as a result of much lower funding increases, limited funds for capital investment, and neglect of workforce planning.
- Although NHS performance held up well on most indicators in the early years of the 2010s, deficits in NHS trusts became widespread by 2014 and the NHS failed to hit key waiting time targets in 2014 and the following years.
- Performance continued to decline for the rest of the decade, with the NHS and social care both showing signs of growing stress across all services, including mental health, learning disability services, primary care and community services.
- Constraints on social care spending resulted in fewer people receiving publicly funded social care and a repeated cycle of governments promising to reform social care but failing to do so.
- Long-term improvements in population health either stalled or went into reverse after 2010, and successive governments were reluctant to use their regulatory and fiscal powers to tackle the wider determinants of health.
- Cuts in the public health grant to local authorities hindered work to improve population health.
- Increases in NHS activity and funding since 2000 have been much greater in hospitals than other services and this has hindered ambitions to deliver more care in people's homes or closer to home.
- The coalition government (2010–15) and successive Conservative governments since then have failed to heed the warning signs of deteriorating performance and preferred to use short-term fixes rather than seek long-term solutions.

## Where next?

- The improvements that occurred between 2000 and 2010 demonstrate that the NHS is capable of reform if the political will exists and if governments take a long-term perspective.
- NHS revenue funding should increase in line with the long-term average. There should be realistic targets for efficiency savings, and spending on capital, education and training, and public health should be given priority.
- Gaps in social care funding must be filled and there must be fundamental changes to social care funding and provision.
- Priority must be given to investing in primary care and community services in order to anticipate people's needs, promote independence and offer alternatives to hospitals.
- There must be a credible and fully funded workforce plan for the NHS and, ideally, social care.
- There should be a sustained commitment to prevention and early intervention, both in the NHS and in other public services, to tackle the wider determinants of health and reduce inequalities.
- The public must be fully engaged in improving health and care, and patients and the public seen as active agents in their care, with responsibilities as well as rights.

# Introduction

The broad sweep of developments in the NHS over the past two decades is well known. A crisis in delivering care to patients in the winter of 1999/2000 led the then Labour government to commit to multi-year funding increases on an unprecedented scale. These increases and associated plans for specific services resulted in improvements in many areas of care through the use of targets and performance management, choice and competition, and inspection and regulation.

An independent assessment found that by the end of the 2000s 'there had been considerable progress in moving the NHS towards being a high-performing health system' (Thorlby and Maybin 2010, p 5), and public satisfaction reached an all-time high in 2010 (Wellings *et al* 2022). This was the verdict of the National Audit Office (NAO):

*The increased money going into NHS hospitals has helped deliver more, better paid staff, reduced waiting times, higher quality care and improved hospital facilities. Until the end of 2009, the Department [of Health] has focused on delivering national priorities – through a combination of targets, performance management, incentives and guidance – within a fixed budget. This has resulted in improvements in, for example: inpatient median waiting times from 12.9 weeks in 2000 to 4.3 weeks in 2010; outpatient waiting times from 4.8 weeks in 2005 to 2.7 weeks in 2010; and the percentage of patients treated in A&E [accident and emergency] within four hours from 78 per cent in 2003 to 98 per cent in 2009.*  
(NAO 2010, p 7)

These improvements stemmed from the NHS Plan (Secretary of State for Health 2000) and the additional funding recommended in the Wanless report (2002). Substantial increases in staffing and pay resulting from new contracts created the capacity for the NHS to cut waiting times for treatment and improve high-priority areas of clinical care such as cancer and cardiac care (Blythe and Ross 2022; Wanless *et al* 2007). The establishment of the National Institute for Clinical Excellence (NICE) and work on national service frameworks helped ensure that resources were targeted at priority areas of care.

The global financial crash of 2008 and the election of a Conservative/Liberal Democrat coalition government in 2010 heralded a marked change of direction. To restore

stability in the public finances, the government introduced tight restrictions on public spending in its first spending review as it embarked on one of the biggest reorganisations of the NHS in its history. The NHS was required to manage with real-term increases in its budget lower than the long-term average and much lower than in the previous decade.

Even greater constraints were imposed on other public services, which experienced real-terms cuts in spending of 20 per cent over the decade to 2019/20 (Zaranko 2020, p 263). These other services, including housing and education – sometimes referred to as the wider determinants of health – had a direct bearing on demand for health and care. Local authorities were under a legal obligation to balance their budgets and were required to make increasingly difficult decisions on the use of resources, including on social care and public health.

The Conservative government elected in 2015 continued to exercise tight control over public spending in what became known as a decade of austerity. The increases in NHS spending agreed by the government were insufficient to deal with the costs of rising demand and deficits that had built up after five years of constraints. Winter pressures from 2014/15 onwards made the effects starkly visible as patients encountered overcrowded A&E departments, long waits on trolleys for hospital beds, and cancelled operations.

The cumulative impact of a decade of insufficient funding and ever more ambitious targets for efficiency savings was exposed during and after the Covid-19 pandemic. Shortages of ventilators and intensive care beds were a major concern in the early stages; capacity constraints hampered the ability of the NHS to work through backlogs in elective care in the later stages; and pressures on urgent and emergency care intensified, leading to concerns about patient safety and excess deaths resulting from delays in ambulance response times and overcrowded emergency departments (McDonald *et al* 2023).

## About this report

This paper analyses how a major public service that is highly valued by the public (Buzelli *et al* 2022) was allowed to deteriorate. It focuses on the period since 2010 and the factors that contributed to the decline of the NHS after the progress that had been made in the previous decade. The paper reviews the various policies that were put in place and their impact on finances, performance and on patients and the public. It shows how many individual decisions help explain what happened, as well as big choices on public spending.

The first part of the paper provides a detailed narrative account of developments between 2010 and 2020. The second part offers an analysis of the factors that contributed to decline. These factors included decisions on public spending, rising demand for care, and the failure of politicians and the system in which they operate to heed the warning signs and act accordingly. The paper concludes by setting out what now needs to be done to sustain and reform the NHS.



# Telling the story

## The Nicholson challenge

A starting point for this story is the NHS chief executive's annual report for 2008/9, in which David Nicholson – who had been appointed in 2006 to tackle deficits across the NHS and had done so successfully – warned that the NHS should prepare for a much tighter financial environment (NHS Business Services Authority 2009). His report held out the prospect that 'investment will be frozen for a time' in the light of the global financial crash and its impact on the public finances. More specifically, Nicholson argued that the NHS would need to deliver productivity improvements of between £15 billion and £20 billion between 2011 and 2014 in order to keep pace with rising demand and improve the quality of care.

This became known as the Quality, Innovation, Productivity and Prevention (QIPP) initiative and, more popularly, as the Nicholson challenge. Nicholson emphasised the importance of focusing on quality in improving productivity, drawing on the approach outlined in *High quality care for all* (Secretary of State for Health 2008), rather than cutting costs alone. His view was that savings could be made while improving the quality of care but not indefinitely. QIPP was therefore 'a holding operation until the next spending review' (personal communication) on the assumption that NHS spending constraints would be short-lived.

For the avoidance of doubt, the Nicholson challenge was designed to deliver efficiency savings and was not about making cuts in services. In evidence to the Public Accounts Committee (2011), Nicholson explained that 40 per cent of these savings would be delivered by reducing the prices hospitals were paid for the work they do. Another 40 per cent would result from the government's public sector pay freeze, controls over management costs and reductions in central budgets. The remaining 20 per cent derived from service changes such as moving care from hospitals to the community.

The QIPP programme delivered efficiencies of £5.8 billion in 2011/12, £5 billion in 2012/13, and £4.3 billion in 2013/14 (Lafond 2015; Appleby *et al* 2014a). The biggest items were cuts to the prices paid to providers and the staff pay freeze. When deficits began to appear in 2013/14, they were concentrated in NHS trusts that were most affected by reductions in the prices they were paid.

Nicholson explained that NHS trusts were given responsibility for delivering efficiency savings because 'I could not point to a single efficiency programme that had been delivered by commissioners in the past nor could I point to a single recovery programme that had been delivered by commissioners without the injection of growth money' (personal communication). He also aimed to build up significant surpluses at the centre and among commissioners that could be used as a 'war chest' by NHS England when it was established in 2013.

An audit undertaken by The King's Fund of the coalition government's record on the NHS concluded:

*Our analysis shows that NHS performance held up well for the first three years of the parliament but has since come under increasing strain. This has been particularly evident on finance and the achievement of waiting time targets, especially in 2014/15 when winter pressures catapulted the NHS back into the headlines. Failure to hit the target that 95 per cent of patients should wait no longer than four hours in A&E departments, increases in the number of patients waiting to be discharged from hospital and rising numbers of providers in deficit pointed to a service operating at and sometimes beyond capacity.*

(Appleby et al 2015a, p 54)

The quarterly monitoring reports (QMR) published by The King's Fund beginning in April 2011 tracked the impact of spending constraints by using publicly available data on NHS performance and views from a panel of NHS finance directors. The QMR published in January 2014 found that more than one in five hospitals would be in deficit by the end of the financial year. Many NHS trusts used funds carried over from previous years and surpluses built up when NHS funding was growing at a faster rate to balance their books. These measures helped paper over the cracks but did not address the underlying causes of financial distress.

The QMR published in October 2014 found that 'financial difficulties have spread beyond those organisations with a history of problems balancing their books and is [sic] now endemic across the system' (Appleby et al 2014b). Subsequent surveys confirmed these trends, with 114 providers ending 2014/15 in deficit and a net overspend of £800 million despite the transfer of resources from capital to revenue (Appleby et al 2015b). Capital to revenue transfers continued in subsequent years and amounted to £4.3 billion in the five years from 2014/15 to 2018/19 (NAO 2020b, p 7).

The war chest created under the Nicholson challenge and underspending in some centrally held budgets enabled the NHS as a whole to balance its budget. This was in the context of the aggregate position in NHS trusts moving into deficit in 2013/14 and in foundation trusts in 2014/15 (Appleby *et al* 2015a). Financial performance continued to decline in subsequent years, with The King's Fund noting that 'rising costs, cuts in the payments they receive for treating patients and increasing demand make 2015/16 the most challenging year for NHS providers this century' (Appleby *et al* 2015b).

Concerns about the size of NHS deficits raised the possibility that the Department of Health might breach its spending limit in 2015/16. This was narrowly avoided on a technicality but it was a close-run thing (Hawkes 2016). Even the best efforts of experienced finance leaders to move money around to balance budgets at a national level appeared to have reached their limits.

Notwithstanding concerns about pressures in A&E departments in 2012/13, performance against waiting time targets held up in 2013/14 – helped in part by a relatively mild winter. Relief was short-lived, however, and 2014/15 was the worst year for breaches of the national 18-week target for admitted patients since it was announced in 2004 and achieved in 2008 (Appleby *et al* 2015b). Hitting waiting time targets became even more difficult in 2015/16, with The King's Fund reporting that on the five main waiting time measures, average performance across the NHS was poor (Appleby *et al* 2016).

In its assessment of the state of care in 2015/16, the Care Quality Commission (CQC) stated that while some health and care services were improving, others were not, and there was evidence of a deterioration of quality (CQC 2016, p 6). A particular concern was the fragile state of social care, which was at a 'tipping point' despite the government allocating some additional funds to help councils meet rising demand.

Throughout this period, NHS leaders were working to implement the coalition government's reforms devised by Health Secretary, Andrew Lansley, and famously described by David Nicholson as 'the only change management system that you can actually see from space – it is that large' (Timmins 2018, p 41). These reforms, which were designed to embed competition in the NHS, abolished strategic health authorities and primary care trusts, resulting in the loss of many experienced NHS leaders. Time that could have been spent improving NHS efficiency was directed to restructuring, which was widely perceived as both damaging and distracting.

The NHS was also focused on responding to the findings of the Francis report into failures of patient care at Mid Staffordshire NHS Foundation Trust ([Mid Staffordshire NHS Foundation Trust Public Inquiry 2013](#)). This was a high priority for Jeremy Hunt, who took over from Lansley as Health Secretary in 2012. Among other things, NHS organisations sought to ensure that they had safe staffing levels, including recruiting additional nurses, midwives and related staff. Many organisations relied on agency staff for this purpose and the high cost of these staff put further pressure on overstretched budgets.

### The Stevens challenge

David Nicholson left office warning of the risk of ‘managed decline’ in the NHS ([Johnston 2014](#)) and was superseded by Simon Stevens as chief executive of NHS England in April 2014. Stevens’ plans for the NHS were set out six months later in the *NHS five year forward view*, which proposed the development of new care models with the aim of transforming service delivery ([NHS England et al 2014](#)). These care models were designed to achieve closer integration of care in response to changing needs in the population.

The Forward View highlighted the financial challenges facing the NHS and social care and formed the basis of discussions between Stevens and the Treasury on how the expected funding gap of £30 billion by 2020/21 could be filled ([Timmins 2018](#), pp 68–70). This funding gap and the required efficiency savings became known as the Stevens challenge.

The Forward View was explicit in recognising that delivering efficiency savings depended on action on prevention to reduce demand. It also underlined the need to sustain and improve social care and bring about system-wide improvements in care. Stevens’ core message was that ‘there *are* viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local ([NHS England et al 2014](#), p 5 [original emphasis]).

The government announced a down payment on future investment of £2 billion in December 2014 ahead of a commitment in the Conservative Party’s election manifesto in 2015 to an overall increase of £8 billion by 2020/21. The 2015 spending review delivered on this commitment with additional funding frontloaded to 2016/17 in recognition of the scale of financial deficits across the NHS. The extra resources earmarked for the NHS derived in part from cuts in other

Department of Health budgets, including public health spending, capital spending, and education and training.

Extra resources were intended to tackle deficits and fund transformations in care, building on the new care models announced in the Forward View. The vehicle for doing so was sustainability and transformation plans (STPs) (later renamed as partnerships), which brought together NHS organisations and their partners in more than 40 areas of England to plan and deliver system-wide improvements in health and care for their populations. STPs were at the heart of Stevens' vision to integrate health and care more effectively. Without actually altering legislation, the reforms he led had the effect of reversing many of the market-oriented changes introduced by the coalition government.

This did not prevent critics from arguing that STPs would lead to greater privatisation of NHS provision and open the door to the introduction of accountable care organisations, drawing on experience in the United States. These concerns were accentuated by the speed at which STPs were introduced and the lack of transparency in their operation. Local authorities and voluntary and community sector organisations expressed concerns that they were being marginalised. Critics' fears were fuelled as plans emerged in some areas for radical changes in service provision, including major reductions in the number of hospital beds (Alderwick *et al* 2016).

In the context of a requirement on the NHS to find £22 billion of efficiency savings to meet the Stevens challenge, it was not surprising that work on STPs increasingly focused on ways of achieving financial balance as well as developing new care models. This helps explain proposals in some areas to cut back on hospital services in order to invest in primary care, community services and other priorities. Changes in guidance from NHS England on what was required added to the challenges faced by STP leaders (Alderwick *et al* 2016).

The King's Fund found widespread scepticism among finance directors that the necessary savings could be delivered (Appleby *et al* 2016). Events showed their scepticism to be well founded, with NHS organisations struggling to balance their books and hit waiting time standards even with the additional resources committed by the government. While the frontloading of the 2015 settlement was welcomed, the consequences for patient care of lower increases in 2017/18 and beyond were a major concern.

One of the challenges in managing deficits was fragmentation among the national bodies responsible: NHS England, Monitor, and the Trust Development Authority (Timmins 2018, pp 72–74). Steps were taken to address this fragmentation by requiring Monitor and the Trust Development Authority to merge in all but name in 2015. The resulting body, NHS Improvement, worked ever more closely with NHS England until their formal merger in 2022. Notwithstanding these workarounds, the lack of a unified centre – a legacy of Andrew Lansley’s reforms – undoubtedly hindered efforts to restore financial stability in the NHS.

A former senior civil servant interviewed for this paper made a related point in emphasising the loss of NHS knowledge and expertise in the Department of Health after the establishment of NHS England, when many senior staff left the Department to work at NHS England. Instead of providing leadership of the whole health and care system, the Department focused on its role as a department of state. This meant that the ‘top of the office’ lacked people with a deep knowledge of health and care able to advise ministers on what needed to be done (Douglas, personal communication).

Towards the end of 2017, Stevens took the unusual step of speaking publicly about the impact of several years of constrained funding, stating that ‘The NHS can no longer do everything that is being asked of it’ (Stevens, cited in Ham 2017b). His comments aligned with remarks by David Nicholson after he left office, in which he criticised the leaders of all political parties for not facing up to the scale of the problems in the NHS and social care (Campbell 2015). Stevens suggested that one way of increasing NHS funding would be for the government to honour the commitment made during the referendum on European Union (EU) membership by the Leave campaign and provide the NHS with an additional £350 million a week.

Following tense discussions in Whitehall, Stevens’ arguments eventually bore fruit when the then Prime Minister, Theresa May, promised additional funds for the NHS to coincide with its 70th anniversary in July 2018. In the event, the government committed increases of around £20 billion over five years equating to annual real-term increases averaging 3.4 per cent. These increases were below those advocated by The King’s Fund, the Health Foundation and Nuffield Trust, and they applied only to NHS running costs – as in the 2015 spending review settlement – thereby excluding funding for public health, capital expenditure, and workforce training and development.

Stevens set out in the NHS Long Term Plan in January 2019 how these funds would be used and the benefits they were expected to deliver through integrated care systems (ICSs), the successors of STPs (NHS England 2019). Throughout this period, he also continued to emphasise, alongside Jeremy Hunt, Secretary of State for Health and Social Care, the need for social care to receive additional funding. Failure to reform social care in line with the recommendations of the Dilnot Commission was a legacy of the coalition government, as was the use of the Better Care Fund, introduced in 2013 to channel some NHS resources into social care and promote the use of pooled budgets. The government also allowed local authorities to increase council tax to raise extra resources for social care.

Timmins (2018) argues that Stevens' negotiations with Theresa May and her chancellor, Philip Hammond, were more difficult than with David Cameron and George Osborne because May and Hammond had not been involved in Stevens' appointment and were more sceptical than their predecessors of claims for increased spending. This was in part because May and Hammond had both run spending departments that had been affected by austerity and were not convinced that extra funding really was needed to avoid a further deterioration in patient care. The fact that independent organisations such as The King's Fund and the Institute for Fiscal Studies (IFS) were making the case for additional funding strengthened Stevens' hand, as did increasingly blunt warnings about the state of the NHS and social care from the CQC (CQC 2017).

As the CQC noted in its 2018/19 state of care report:

*There is pressure on all health and care services in England. Waiting times for treatment in hospitals have continued to increase and, like many areas in the NHS, demand for elective and cancer treatments is growing, which risks making things worse. In hospital emergency departments, performance has continued to get worse while attendances and admissions have continued to rise. July 2019 saw the highest proportion of people spending more than four hours in A&E than any previous July for at least five years. What used to be a winter problem is now happening in summer as well. While other hospital services improved slightly this year, the quality of care in NHS urgent and emergency services in hospitals has deteriorated. The stability of the adult social care market remains a particular concern.*

(CQC 2019, p 7)

The CQC's 2018/19 report highlighted challenges in mental health and learning disability services as a particular concern. These challenges included people with



severe and enduring mental ill health being in inappropriate placements far from home, and people with learning disability or autism being hospitalised, segregated and placed in overly restrictive environments.

The CQC argued that more and better community care services were needed to help people avoid crisis situations. And although the overall quality of primary medical services was high, the CQC reported that accessing services could be a challenge, foreshadowing rising pressures on general practices that were to become a much bigger problem in the years that followed. The CQC emphasised the need for more support to be given to innovation – for example, in the development of new staff roles and the use of technologies to deliver care in more effective ways.

As the decade drew to a close, and before the pandemic struck, The King's Fund's quarterly monitoring reports found that performance against waiting time targets remained poor and financial deficits persisted, notwithstanding the additional resources committed by the government (Anandaciva and Ward 2019). Finance directors were pessimistic about NHS England's expectation in the NHS Long Term Plan that the provider sector would meet targets to achieve financial balance in 2020/21 and that all NHS organisations should be in balance by 2023/24. They were also concerned about underinvestment in social care, capital spending, the NHS workforce and public health.

The NAO reported that NHS trusts bridged the gap between income and expenditure with top-up loans from the Department of Health. Between 2015/16 and 2019/20, the amount loaned increased from £5 billion to £15 billion, of which £13 billion related to interim loans mainly used for day-to-day expenditure. In April 2020, £13.4 billion was written off by the Department in recognition that there was no prospect that the monies would be repaid. The NAO described these arrangements as 'not fit for purpose and unsustainable' (NAO 2022, p 33).

## The NHS in the international context

International assessments have noted the strengths of the NHS alongside its weaknesses, including poor outcomes of care as measured by cancer survival rates, deaths associated with cardiovascular disease, and infant mortality. In its analysis, the Organisation for Economic Co-operation and Development (OECD) highlighted cancer care as an example of how 'on international benchmarks of health care quality... some indicators for the United Kingdom show average or disappointing performance' (OECD 2016, p 29). These findings were echoed in a review of OECD



data conducted by The King's Fund, the IFS, the Health Foundation and Nuffield Trust (Dayan *et al* 2018).

The review found that the UK performed less well than other countries on several indicators of health outcomes, including the rate at which people died when successful medical care could have saved their lives. Published to coincide with the 70th anniversary of the founding of the NHS, the review concluded that 'the NHS performs neither as well as its supporters sometimes claim nor as badly as its critics often allege' (Dayan *et al* 2018, p 4). This was in line with surveys carried out by the Commonwealth Fund (Schneider *et al* 2021; Davis *et al* 2010) showing the UK falling from 2nd in the rankings of 7 countries in 2010 to 4th out of 11 countries in 2021.

The absence of financial barriers to people accessing care in the UK remained a strength throughout the decade.

A major study carried out by a commission set up by *The Lancet* and the London School of Economics and Political Science (LSE) concluded:

*Many health outcomes are substantially worse in the UK than in other high-income countries... most of which spend a greater proportion of GDP [gross domestic product] on health and care... This Commission argues that not only can the UK, as a wealthy country, afford to increase spending on health but also that spending should increase if the UK's poor health outcomes, relative to other EU15<sup>1</sup> and G7 countries, are to be improved and that additional health expenditure can benefit macroeconomic growth and societal welfare... the effect of low amounts of health spending in the UK, relative to other EU15 and G7 countries, is compounded further by relatively low amounts of spending on social care.*

(Anderson *et al* 2021, p 1920)

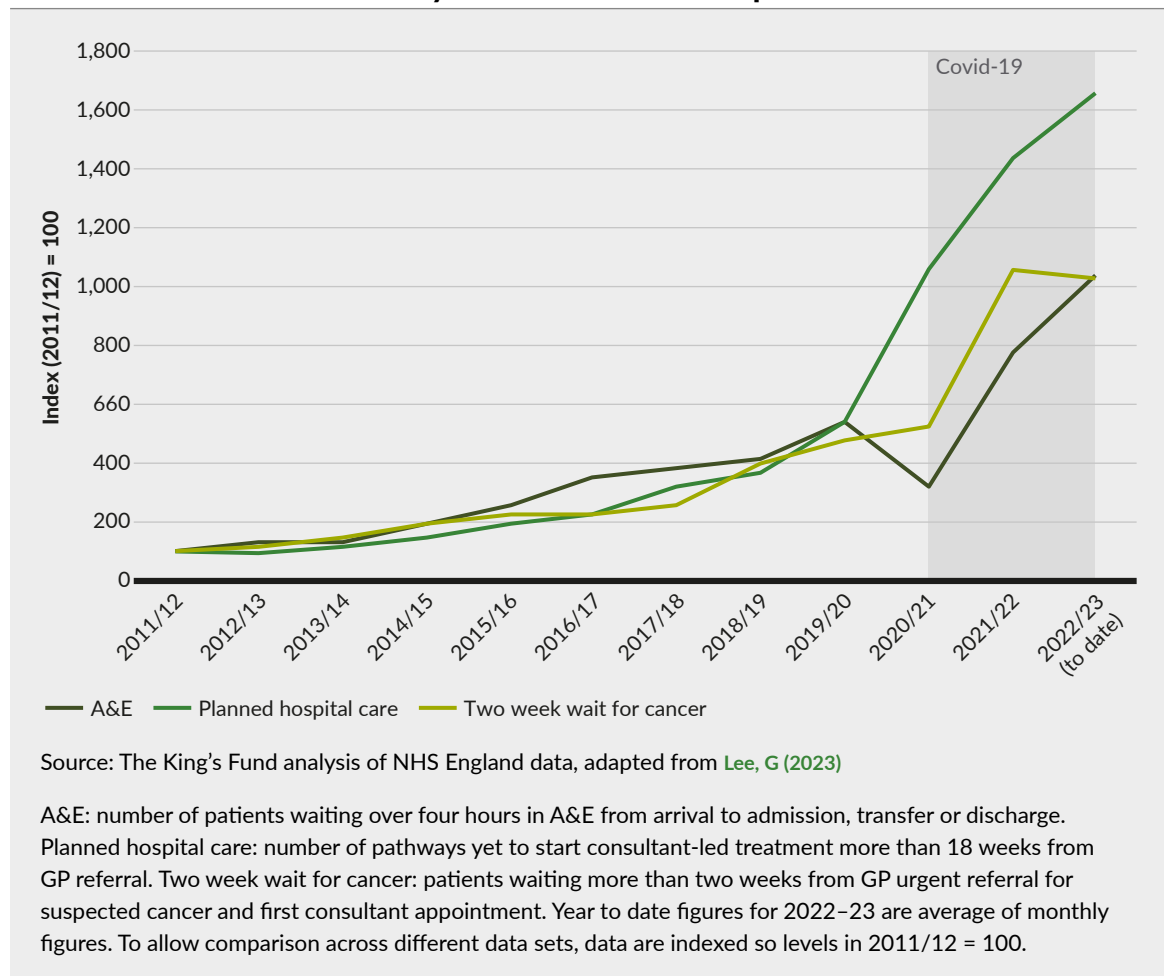
It might be added that public satisfaction with the NHS fell to its lowest level in over a decade in 2018 and to its lowest level since 1997 in 2021 (Wellings *et al* 2022). Despite these falls, there continued to be strong support for the NHS among the British people. Claims by some commentators that the NHS model was fundamentally broken and that the UK would be better served by adopting the social insurance systems used in parts of Europe appeared to have little public support.

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1 EU15 describes the 15 countries in the EU before 2004 and before the UK exited: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the UK

There was, however, widespread recognition of the extent to which patient care had deteriorated during the decade (Davies *et al* 2022). The impact on waiting times was particularly stark as slow declines in performance in the early part of the decade accelerated towards its end (Lee 2023; Baker 2022).

**Figure 1** Waiting times for NHS cancer care, planned routine hospital treatment and A&E care have substantially deteriorated over the past decade **K**



# Explaining the decline of the NHS

The above account makes clear that funding pressures in the NHS and social care played a major part in deteriorating performance between 2010 and 2020. We now go on to put these pressures in context and to discuss the other factors that contributed to the decline.

These factors include failures to moderate rising demand for care resulting from a growing and ageing population. Ill health within the population (*see below*) has added to the pressures on services and the needs of people with multimorbidity present challenges to specialist models of care focused on single diseases ([Whitty 2017](#)). Failure to implement policies designed to address these challenges contributed to decline.

Analysis of trends in NHS activity and spending between 2000/1 and 2017/18 showed that growth was greater in hospitals than in primary care and community services. This was despite policy commitments to shift care and resources away from hospitals and into the community, and to develop new care models. The analysis concluded that primary and community services were therefore ‘struggling to meet the demands of a population with an increasing number of long-term complex conditions’ ([Tallack \*et al\* 2020](#), p 68). The NAO reported that the proportion of the NHS budget spent on primary care and community services fell between 2015/16 and 2018/19 ([NAO 2020a](#), p 10).

As noted earlier, there were also real-terms cuts in public spending outside health care of 20 per cent over the decade to 2019/20. One assessment noted that ‘Cuts to housing and communities budgets have left Britain’s dwellings in such a dire state that they are now causing deaths among children’ ([Burn-Murdoch 2022a](#)). Awareness of these wider determinants of health was not new but became more visible as a result of austerity.

## Constrained resources

Long-term trends in NHS spending show average annual increases of around 3.6 per cent in real terms (Warner and Zaranko 2022). There were wide variations around the average, with the lowest increases in England occurring between 1982/83 and 1985/86 and the largest between 1999/2000 and 2003/4 using five-year moving averages (Harker 2019). These differences can be explained by the state of the economy and public finances as well as political choices by the government of the day.

Another way of looking at spending is to adjust funding increases for changes in the size and composition of the population. On this basis, analysis shows that health care spending per person adjusted by age grew by 2.6 per cent a year in real terms between 1979/80 and 2020/21, with the biggest increases occurring between 1997 and 2010 and the lowest in the period after 2010 (Appleby and Gainsbury 2022). These comparisons underline the squeeze exerted on the NHS.

International comparisons show that UK health spending would have been £40 billion higher every year between 2010 and 2019 if it had matched the EU14<sup>2</sup> average (Rebolledo and Charlesworth 2022). Comparisons also demonstrate that health care capacity in the UK is lower than in many other countries as seen in the number of hospital beds, doctors and nurses, and medical equipment such as scanners.

Earlier in this report, we noted that governments sought to protect spending on NHS running costs by diverting resources from other parts of the Department of Health's budget such as capital spending and reducing spending on public health, education and training, and central administration. Decisions taken in the 2015 spending review amounted to a cut of more than 20 per cent in these other budgets or more than £3 billion in real terms by 2020/21 (Nuffield Trust *et al* 2015).

The effects were felt in reduced funding for local government via the public health grant to invest in prevention; cuts in training budgets, which included removing bursaries for nursing students and lengthy delays in developing a fully funded workforce plan to address growing staff shortages; a growing maintenance backlog, giving rise to concerns about the safety of NHS buildings; and lack of funds for new hospital buildings and investment in information technology (Warren 2022).

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<sup>2</sup> EU14 refers to: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, and Sweden.

A former senior Treasury official who chairs an NHS trust has criticised NHS England and the Department of Health and Social Care for favouring headline increases in NHS spending at the expense of these other budgets (Gieve, cited in [Anderson 2023](#)).

### Efficiency savings

One of the consequences of funding constraints was to put the onus on NHS organisations to find ever more challenging, and often less credible, efficiency savings. Some of these savings were delivered by blunt controls over staff pay and the prices paid to providers, and others by attempts to put in place new care models. Non-recurrent savings also contributed and by definition were only a short-term stop-gap. NHS organisations increased productivity year-on-year by an average of 0.8 per cent but this was insufficient to fill the funding gap.

The persistence of deficits in many organisations reflected the difficulty of realising sustainable savings while at the same time delivering safe standards of care. The impact was not felt immediately after the general election in 2010 as funding increases in the previous decade meant that the balance sheets of most NHS organisations were healthy. As opportunities to increase efficiency became more difficult to identify, some organisations sought to grow income, sell assets and explore other options for balancing their budgets. The escalating costs of hiring staff to fill vacancies added to the challenge, as NHS organisations became increasingly dependent on agency staff.

Reflecting on these issues, The King's Fund observed that:

*There is little doubt that compared with earlier periods when the NHS was faced with tightly constrained budgets, there is now much less scope for containing or cutting costs by diluting the quality of care. Deliberately allowing waiting lists to lengthen or not filling staff vacancies when they arise – methods used in the 1990s, for example – are off the agenda because of the priority attached by successive governments to improving access and quality of care combined with ever closer scrutiny of NHS performance by regulators and others. In these circumstances loss of financial control becomes the main safety valve, providing that government is prepared to sanction overspending. With the NHS now topping the list of the public's concerns ahead of the election campaign, ministers have had little choice other than to find additional resources to deal with deficits to reassure voters about their intentions and commitment to the NHS.*

*(Appleby et al 2015a, pp 55–56)*

NHS England used various mechanisms such as financial control totals and transformation funds to rein in deficits but with limited success. The priority given to sustaining services also meant that funds intended to support transformation were not always used for this purpose. This held back the development of the new care models at the heart of the Forward View and the NHS Long Term Plan. Analysis of OECD data showed that the UK allocated more of its health care budget to hospital care and less to preventive, residential and outpatient care than in comparable countries (Burn-Murdoch 2022c).

Failure to invest more in services in the community hindered efforts to reduce demand for hospital care and respond to the changing burden of disease. One study noted that growth in the workforce was greater in hospitals than in general practice, resulting in ‘more capacity for doctors to refer patients and to undertake outpatient procedures as technology advanced’ (Tallack *et al* 2020, p 61). This study found that elective procedures grew by 9.6 per cent each year compared with growth of GP consultations of only 0.7 per cent per year between 2000/1 and 2017/18 (Tallack *et al* 2020, p 33).

The expansion of activity and funding in hospitals is one factor that has contributed to rising demand and the pressures on urgent and emergency care. The recently published plan for recovering urgent and emergency care services recognises this in setting out proposals for expanding care in the community and people’s homes (Department of Health and Social Care and NHS England 2023). While the plan is welcomed, it misses an opportunity to support patients to manage their own care more effectively and avoid the need for hospital care. We return to this point in the final part of this paper.

## Capital spending

International comparisons show that capital spending in the NHS is lower than in comparable countries (Kraindler *et al* 2019). The NAO found that the UK invested the least in health care capital per head across the OECD (NAO 2020a, p 32). This had two main consequences.

The first was that maintenance arrears were neglected. The bill for carrying out this work is currently estimated to be more than £10 billion. This includes the cost of repairing hospitals with structural defects such as leaking roofs that create risks for staff and patients. Analysis suggests there has been a gradual deterioration in the condition of the NHS estate since 2013 (Warner and Zaranko 2022).

The second was that funds for new buildings and the purchase of equipment were in short supply. Spending on information technology and other investments with the potential to transform care was also challenging. This acted as a brake on the development of new care models and the gains in productivity they offered.

Decisions taken during spending reviews to increase headline allocations to the NHS by cutting capital spending help explain how this happened. In-year transfers of funds from capital budgets to cover revenue deficits resulting from low funding increases also contributed. To make matters worse, the NAO found that in the early 2010s, the NHS underspent the available capital budget (NAO 2020b).

The IFS's view is that 'the government's approach to capital spending in recent years has not lent itself to the effective planning and delivery of investment in the health service' (Stoye and Zaranko 2019) while another analyst has described the UK's record on capital investment as 'truly worst-in class' (Burn-Murdoch 2022c). The House of Commons Public Accounts Committee noted recently that the government promised to publish its long-term strategy for capital in autumn 2020 but by the time of writing it had not appeared (Public Accounts Committee 2023).

### Workforce planning

Failure to publish a credible workforce plan in the 2010s was particularly consequential given that improvements in NHS performance between 2000 and 2010 resulted in part from substantial increases in staffing and pay, as noted at the beginning of this paper. Persistent vacancies, increasing reliance on agency staff and, latterly, concerns about retaining staff in the context of the pandemic and the huge pressures facing the NHS and social care demonstrate the urgency involved. A review by the Health Foundation, The King's Fund and Nuffield Trust set out what needs to be done and the scale of investment required (Beech *et al* 2019).

Workforce shortages are as old as the NHS and reflect failures to train enough staff in the UK. This has resulted in reliance on international recruitment. Brexit and political debate about immigration to the UK have raised questions about this source of staff, not least because of ethical concerns about recruitment from countries that also require staff to sustain their own health services (McCarey *et al* 2022). Staff pay and conditions are also a major consideration, as demonstrated by industrial action in early 2023 in the midst of the cost-of-living crisis and rising inflation. The pandemic's toll on staff health and wellbeing has accentuated an already difficult challenge.

Tackling these issues demands long-term thinking, which at present appears absent. In a highly critical report published in July 2022, the all-party House of Commons Health and Social Care Committee urged the government to publish workforce projections, arguing that ‘Without full and frank transparency on projected workforce gaps, the public and NHS staff can have little confidence that the Government has grasped the depth of the workforce crisis’ ([House of Commons Health and Social Care Committee 2022](#), p 57). NHS vacancies well in excess of 100,000 posts illustrate the scale of the current challenge ([Public Accounts Committee 2023](#), p 14). There are even more vacancies in the social care workforce.

### Social care spending and reform

The interdependence of the NHS and social care has long been recognised, as has the need to put social care on a sustainable footing. It appeared that some progress was being made under the coalition government through enactment of the care cap recommended by the Dilnot Commission in the Care Act 2014. In the event, the Conservative government postponed and then abandoned implementation of the cap and resorted to various short-term measures in an attempt to shore up an increasingly fragile social care market. These measures were intended in part to relieve pressures on the NHS, as seen in increasing numbers of delayed transfers of care and the associated risks of high levels of bed occupancy.

The government’s actions included injecting some additional funds into social care, making use of the Better Care Fund, and allowing local authorities to raise more money for social care through the council tax. While these were welcome moves, they amounted to sticking-plaster solutions in the face of cuts in real-terms spending on social care of 11 per cent per adult resident by councils between 2009/10 and 2015/16, and a reduction of 400,000 in the number of people receiving publicly funded social care ([Bottery et al 2018](#), p 8). The ability of social care providers to continue delivering services under contract to local authorities in the face of spending pressures was brought into question.

The Better Care Fund (BCF) – designed to encourage more pooling of budgets between local authorities and the NHS ([Bennett and Humphries 2014](#)) – was seen as a key innovation by the coalition government. The fund brought together resources from existing budgets, with the majority coming from the NHS. At the time it was introduced, Humphries (2014) commented that ‘the BCF is well-intentioned but no substitute for a proper transformation fund to meet the double-running costs of shifting care closer to home and short-term action to address the gathering financial storm’. Simon Stevens expressed the same point more graphically when



he argued that you do not get a watertight solution when you merge two leaky buckets (Stevens 2014).

The renaming of the Department of Health as the Department of Health and Social Care in 2018 offered hope of a fresh approach to social care, but in practice, Theresa May's government showed little interest in taking up the challenge. One reason may have been the difficulty faced by the Conservative Party at the 2017 general election, when its manifesto abandoned the commitment to introduce a cap on care costs and instead proposed that people should be responsible for these costs until they were left with £100,000 of assets. The manifesto also proposed applying the means test to people receiving domiciliary care by taking into account the value of the family home.

These proposals were quickly dropped in the face of widespread criticism, leaving uncertainty about what, if anything, a future Conservative government would do. In the event, Boris Johnson lent his support to the care cap when he succeeded Theresa May as prime minister – albeit in less generous form than planned by the coalition government – and proposed a health and care levy to pay for it. His resignation in July 2022 and the political turmoil that followed led to the levy being scrapped and implementation of the care cap was postponed. The future of social care was once again thrown into doubt.

Additional funds for social care announced in 2021 by the government have been described as 'derisory in relation to the scale of what needs to be done' (Humphries 2022, p 218). Meanwhile voices outside government argue that attitudes to care and support need to be rethought based on a national care covenant that recognises the role of citizens, families, communities and the state in providing support and paying for it (The Archbishops of Canterbury and York 2023). There is widespread agreement that social care should promote independence and aid recovery, but funding and staffing shortages make this difficult.

The Conservative government published a vision for adult social care in December 2021 (Department of Health and Social Care 2021) with three objectives.

- People have choice, control, and support to live independent lives.
- People can access outstanding quality and tailored care and support.
- People find adult social care fair and accessible.

There remains a large gap between these objectives and the experience of many people using social care after a decade of austerity.

One of the constraints on progress during the past decade has been lack of expertise in and understanding of social care among officials in the Department of Health and Social Care, despite the Department having had responsibility for social care before its change of name. This was exposed early on in the Covid pandemic when the government had to act quickly to fill gaps in its capabilities in order to provide support to a sector at the forefront of the response. The government appointed an experienced social care leader and set up a Social Care Sector Covid-19 Task Force to ensure that social care providers received some of the support they needed (Ham, forthcoming).

This kind of expertise was not available in the Department of Health after the departure in 2016 of Jon Rouse, the last person to serve as Director General for social care, local government and care partnerships. Rouse and his predecessors such as David Behan and Denise Platt played a vital role at the centre, and the loss of their credibility and experience left a vacuum that was widely criticised by social care leaders (Humphries and Timmins 2021). It also meant there was little counterbalance within the Department to declining political interest in social care. The lack of a senior voice able to speak on behalf of the social care sector did not help.

### Preventing ill health

Taking a longer-term perspective, it can be argued that the root causes of the deterioration of NHS performance were located in the failure of successive governments to act on the insights of the 2002 Wanless Review and its argument that the NHS would become unsustainable unless the population was ‘fully engaged’ in preventing illness and promoting health:

*The desirable health outcomes depicted in the fully engaged scenario are only likely to come about with a step change in the way public health is viewed, resourced and delivered nationally. This will support a future public more engaged in maintaining their health... The benefits of reaching such a situation are large: significantly better health outcomes for the same or lower expenditure... Thanks to the health outcome benefits associated with investment in public health, the UK would find itself much better placed to deal with such pressures under the fully engaged scenario...*

(Wanless 2002, p 118)

By not taking the road advocated by the Wanless Review, there was insufficient attention to prevention and the wider determinants of health, despite Andrew Lansley’s ambition that the Department of Health should become a department for public health. Analysis shows that improvements in population health stalled

or went into reverse during the 2010s at the very time when risk factors such as obesity – for which the UK has the highest rates in Europe – were having an increasing impact (Buck *et al* 2018).

The poor health of the population was reflected in rising demand for care (Baker 2022) and contributed to the UK having high rates of excess deaths from Covid-19 and other causes. The effects were particularly stark in the most deprived communities and in the Black and Asian population. Increased mortality from Covid-19 and other causes contributed to reductions in life expectancy in 2020 of 1.3 years for males and 0.9 years for females, resulting in the lowest life expectancy since 2011 (Fitzpatrick and Roberts 2021). Growing numbers of people who are economically inactive as a result of ill health are another cause of concern (Burn-Murdoch 2022b; Tinson *et al* 2022).

The Global Burden of Disease study showed that the number of years of life spent with long-term poor health is now greater than the number of years of life lost due to preventable deaths (Steel *et al* 2018). The most common causes of that burden in the UK are back pain, poor mental health, skin conditions, and sight and hearing loss. This means that people are spending more years living in poor health as the gap between lifespan and health span widens.

The Forward View did argue for ‘a radical upgrade in prevention and public health’ (NHS England *et al* 2014) while the NHS Long Term Plan outlined the role of the NHS in prevention and tackling health inequalities (NHS England 2019). There were also aspirations to harness the ‘renewable energy represented by patients and communities’ (NHS England *et al* 2014, p 9). Local examples such as the Wigan Deal and initiatives in other areas to make use of all available assets illustrated the possibilities (Lent *et al* 2022; Naylor and Wellings 2019), but national leadership was lacking.

Various government policies aimed at tackling risk factors such as smoking, diet and physical activity have been proposed in the past decade ‘but many have been abandoned or not moved beyond consultation stage, even where there is strong evidence of their effectiveness’ (Everest *et al* 2022). Minimum pricing of alcohol is an example. A consultation document on prevention was published in 2019, but at the time of writing, the government had yet to publish its response to submissions received during the consultation and the actions it intends to take (Public Accounts Committee 2023).

A major study of obesity policy in England between 1992 and 2020 noted that the policies adopted by government focused primarily on individuals making behaviour

changes, and hesitated to use interventionist approaches (Theis and White 2021). This reflects the reluctance of governments to be seen to be acting as a ‘nanny state’ and a preference for working on the basis of voluntary agreements with businesses – for example, through the Public Health Responsibility Deal launched in 2011. A partial exception is the soft drinks industry levy or ‘sugar tax’, which was enacted in 2016 and came into force in 2018.

Analysis of policies to tackle risk factors has shown how disjointed policy-making has undermined efforts to achieve health improvement targets (Everest *et al* 2022). An inability to learn from previous policy failures and devise policies that lend themselves to implementation has also contributed (Theis and White 2021). A further barrier is that the public health system in England is complicated, with roles and responsibilities shared between a range of national and local bodies and no one agency having a clear leadership role (Buck *et al* 2018).

Responsibility for public health was transferred from the NHS to local government in 2013 but successive governments have failed to provide the resources for councils to fulfil their functions effectively. Reductions in the public health grant to local government since 2015/16, for example, resulted in cuts in spending of 24 per cent per person in real terms and affected many services, including stop smoking services, drug and alcohol services for adults, and sexual health services (Finch 2022). Reductions in spending on other public services such as housing and leisure accentuated the impact of these cuts (Buck *et al* 2018).

### Failure demand

We have seen how NHS activity and spending since 2000 has focused mainly on increasing the supply of hospital services and changing how care is delivered. There has been less attention to the demand side, with work on personalisation being a notable exception.

John Seddon, a systems thinker and writer, has emphasised the role of ‘failure demand’ in public services – that is, demand that arises from the failure to meet people’s needs in the first place (Seddon 2008). Examples in health care include people who repeatedly attend hospital emergency departments because they are unable to access advice from general practices and other sources.

Seddon’s thinking is echoed in a more recent authoritative review of the changing health needs of the population, which concluded that the NHS is focused on ‘responding to failures in other areas of policy’ (McKee *et al* 2021). From this perspective, greater priority should be given to addressing the wider determinants

of health and the behavioural drivers of disease alongside the biological causes (Whitty 2017). Cuts in public spending beyond health care between 2010 and 2020 were a barrier to this happening.

Lessons can be learnt from work done under the most recent Labour government to tackle health inequalities through a combination of the minimum wage, tax and benefit changes to reduce child poverty, policies to promote full employment, the Sure Start programme to give children the best possible start in life, and interventions to improve education, housing and employment (Barr et al 2017). The cross-government approach made an impact on inequalities but was not sustained after the 2010 general election.

The establishment of integrated care systems (ICSs) as statutory bodies in July 2022 offers a fresh opportunity to address these issues. Integrated care partnerships within ICSs provide leadership on population health and they are developing health strategies for their areas. Their work needs to be matched by leadership within government and the articulation of a cross-government strategy, as argued by the NAO (2022) and others. The recently established Office for Health Improvement and Disparities has a potentially important role in this regard (Warren 2021).

The difficulty facing ICSs is that they have inherited financial challenges built up by NHS organisations during austerity and as a result, three-quarters of them are in deficit. As the NAO noted in its review, ‘There is a high risk that ICSs will find it difficult to fulfil the high hopes many stakeholders have for them’ (NAO 2022, p 13). This will undoubtedly constrain the ability of ICSs to increase investment in primary care, community services and prevention in order to moderate rising demand for care and relieve pressure on hospitals, especially at a time when hospitals also lack capacity to meet the demands they are faced with.

## Political failure

Taken together, constrained resources, decisions on how resources should be used within the NHS, and rising demand help to explain the decline of the NHS. Yet just as important has been the failure of politicians and the political system in which they operate to heed the warning signs and act accordingly.

The decline in NHS performance was not only predictable, it was actually predicted (Ham 2014). Various sources – including those drawn on earlier in this paper – pointed to evidence of deteriorating performance and argued that the health and care system had reached a point where patient care was being compromised.

Decline started gradually, but by the middle of the decade, the adverse impacts on patients and staff were plain to see. It was also clear that austerity would continue for much longer than the period envisaged when David Nicholson launched QIPP. The chorus of voices calling on the government to act reached a crescendo.

The winter crisis of 2016/17 was a reminder of the consequences of short-term thinking geared around election cycles and an unwillingness to deal with long-term challenges that are not amenable to incremental policy changes. A preference for adversarial point-scoring rather than cross-party consensus accentuated the problem. A political system seemingly incapable of tackling the root causes of the huge pressures on the NHS and social care seemed, to this observer, as great a concern as the sight of services palpably struggling to deliver acceptable standards of care (Ham 2017a).

The pre-eminent position of the Treasury in managing the public finances was important throughout the period under review. Morgan (2022) has described the consequences for NHS workforce planning, with the Treasury resisting calls to publish workforce forecasts for fear of losing control over NHS staffing numbers and costs. Its fears are underpinned by concerns about value for money of the education and training budget (Morgan 2022).

Public health policy also suffers from short-term thinking and disjointed policy-making. A recent review cited various examples from the past decade, including scrapping the alcohol duty escalator and freezing the fuel duty. It concluded that:

*These examples... are symptomatic of wider government weaknesses in planning effectively for the long term and aligning policies across departments. Such shortcomings can be especially pronounced when addressing complex policy issues such as obesity that have multiple causes and require coordinated cross-government responses.*

(Everest et al 2022, p 26)

While the coalition government and the Conservative government that took its place bear most of the responsibility for failing to respond effectively to growing financial and workforce pressures in the NHS and social care, opposition parties were also at fault. This was evident at the 2015 general election when none of the parties offered policies on a scale commensurate with the challenges that had emerged in the NHS and social care.

Through much of this period, the Labour Party focused on claims that the NHS was being privatised and its reluctance to promise necessary funding increases reduced

political competition to ensure adequate resources were available. At the time of writing, the Labour Party has not committed to funding increases on the scale needed to tackle current pressures, with the Labour leader Sir Keir Starmer stating in his 2023 new year speech that ‘investment is required... But we won’t be able to spend our way out of their [the Conservative government’s] mess’ (Starmer 2023).

It is also worth reiterating here that the Lansley reforms to the NHS and, subsequently, Brexit crowded out opportunities for dealing with other pressing issues. The Lansley reforms diverted time and attention away from work to improve NHS performance and resulted in the loss of leaders experienced in dealing with financial crises. David Cameron later expressed regret that these reforms also diverted attention from social care (Cameron 2019).

Brexit slowed down work on social care reform, as acknowledged by a minister leading this work (Cecil 2019). It also increased the challenges of recruiting and retaining health and care staff from EU countries and created opportunity costs in the work that went into preparing the NHS for the possibility of a ‘no deal’ Brexit. It also put the public finances under further strain. The pandemic did lead to increased financial support for the NHS and social care, but this was scaled back as the pandemic eased.

Structural weaknesses in the political system have been compounded since the Brexit referendum by frequent changes of leadership and divisions in the governing party. The time horizon for action has shrunk as the challenges of building coalitions to support reform have increased. The effects are visible not only in relation to the NHS and social care but also in other areas of public policy, including housing, energy, infrastructure, education and skills.

# Where next? Renewing the purpose of the NHS

We have seen how big choices on public spending starting in 2010 were mainly responsible for the accelerating decline of the NHS in the decade that followed. Failure to increase NHS funding sufficiently, and to provide adequate resources for capital investment and developing the workforce of the future, left a lasting legacy. Neglect of social care and lack of political will to make the fundamental changes needed to put it on a sustainable long-term path were also consequential.

The implications for the future are clear. If current pressures are to be addressed, NHS revenue funding should increase in line with the long-term average. Spending on capital, education and training, and public health must be given priority. Targets for efficiency savings should be realistic, gaps in social care funding filled, and fundamental changes to social care funding and provision agreed. A credible and fully funded workforce plan for the NHS and, ideally, social care should be published.

The NAO has summarised the position as follows:

*Years of short-term funding decisions for the health sector means that resources have moved away from areas of investment in the future, such as the workforce, public health and capital. This will need to be rebalanced to ensure that the ambitions set out in The NHS Long Term Plan are realised. To bring about lasting stability, the NHS needs a financial restructuring programme not just a recovery programme.*

(NAO 2020a, p 12)

The future will be shaped by decisions on these issues and on the ability to moderate demand for care and support, to invest more in primary care and community services, and to recognise the role of patients and the public in improving health and care. The next government must adopt a long-term perspective to avoid repeating the mistakes of the past decade. The improvements that occurred between 2000 and 2010 show that change is possible where the political will exists.

What then are the prospects for the future?



## Spending decisions

Two considerations will influence future spending decisions. The first is that the share of total public spending accounted for by the NHS has grown considerably over the past 20 years but economic growth has been slow for some time (Stoye and Zaranko 2019). It may be difficult for any government to continue the same trajectory even though health spending in the UK was around 20 per cent lower per person than in similar European countries between 2010 and 2019 (Rebolledo and Charlesworth 2022). Recent projections for economic growth, showing the UK lagging behind other countries and the economy expected to flatline for a number of years, underline the challenges facing the next government in determining future funding for the NHS.

The second consideration is that the public remains strongly committed to the NHS and this will weigh heavily on politicians whatever their persuasion. The inherent tension between these two considerations explains why recent governments have sought to control NHS spending until the point is reached where they feel impelled to loosen the purse strings. But in finding extra resources for the NHS, they have failed to recognise that sustaining the NHS requires fundamental reform of social care. Successive governments have also been unwilling to be honest about the consequences of their spending decisions for patients and the public.

Taking the longer-term view, analysis shows that real-terms spending increases on the NHS averaged 4.1 per cent compared with plans of 2.7 per cent (Zaranko 2021). This underlines the argument that future spending reviews should be realistic about the requirements of the NHS to avoid extra funds having to be found to cover deficits when they arise. Experience shows that public resources are used most effectively when NHS organisations and their partners are able to plan how to deploy these resources instead of receiving them at short notice with an expectation that they will relieve pressures rapidly.

## Moderating demand

More resources are necessary but not sufficient. In deciding how these resources are used, there needs to be a much stronger focus on moderating demand for care.

Specifically, there must be greater investment in primary care and community services (including social care) and a sustained commitment to prevention, both in the NHS and through the contribution of other public services. The case for change has been set out in various policy documents and reports in the past decade, including the Forward View and the NHS Long Term Plan.

Despite this, the share of NHS expenditure accounted for by hospitals increased from 62.7 per cent to 65.2 per cent, and the share accounted for by primary and community services fell from 20 per cent to 19.4 per cent, between 2015/16 and 2018/19 (NAO 2020a, p 37). The government and NHS leaders share responsibility for rebalancing expenditure.

Examples of many of the service changes that are needed can be found across the NHS, as in the use of virtual wards and services that reduce hospital admissions and help people live independently at home for longer. The difficulty is that they have yet to be adopted on a sufficient scale to bring about the system-wide transformation required. Investing in capacity to offer alternatives to hospital remains one of the most urgent requirements (Whitaker 2023). This is illustrated by reductions in community nursing where staffing levels fell between 2010 and 2015 and have yet to return to those seen in 2010 despite recent increases (Rees and Hassan 2023, p 22).

Experience in Torbay, Devon – a pioneer of integrated care in the 2000s – illustrates why strengthening community services should be a priority. NHS and council leaders in the area chose to increase the provision of intermediate care to be able to respond rapidly to older people requiring care and support at times of crisis. They were able to do so because of a commitment to pool NHS and social care budgets and the ability to use what were nominally NHS funds to provide more social care. Alignment with general practices was intrinsic to Torbay's approach.

Evaluations showed that these changes led to reductions in the use of hospital beds by older people and in delayed transfers of care from hospital (Thistlethwaite 2011). If national policy-makers had acted on the learning from Torbay and increased staffing in occupational and physiotherapy, community nursing and social care, demand on hospitals across England might have been manageable. Long-term reductions in NHS hospital beds, and much lower numbers of hospital beds in relation to the population served than in many other countries, means that the NHS is often working at or beyond available capacity. This reinforces the case for investing in alternatives to hospitals.

Doing so is even more important at a time when the changing burden of disease requires a reorientation in which general practices work ever more closely with other services to offer care in people's homes or close to home. The new care models proposed in the Forward View sought to move in this direction but their development was slowed as funds intended to support them were used to

tackle deficits in existing services. With transformation taking second place to sustainability, an opportunity was lost to align the supply of care with changes in demand.

Thinking through how resources are used also means giving greater recognition to overtreatment and overdiagnosis – for example, in care at the end of life, when resources may be used on interventions that offer little if any benefit to the individual (Haslam 2022). Initiatives in Scotland on ‘realistic medicine’ and in Wales on ‘prudent health care’ are examples of how these ideas have started to gain traction. Supporting people to use services wisely through initiatives such as shared decision-making and supported self-care is essential if scarce resources are to have the desired impact.

### Sharing responsibility with patients and the public

Patients and the public must also be fully engaged in improving health and care, as Wanless argued in 2002. Research showing that patients who are most able to manage their health conditions have fewer emergency hospital admissions and A&E attendances than those who are less able to do so demonstrates why this is important (Deeny *et al* 2018). Enhanced primary care as part of a compassionate communities intervention in Frome, in Somerset, led by a general practice showed similar results (Abel *et al* 2018).

Changing the relationship between people and those who care for them is essential if people are to become active agents in their care, with responsibilities as well as rights. This means enhancing people’s capabilities to make informed decisions building on examples of where this already happens (Ham *et al* 2018). Care providers as well as patients must be willing to work differently to ensure that patients’ preferences are taken into account (Mulley *et al* 2012). Support should be tailored to the needs of different individuals and communities.

Moving in this direction means learning from the work of Hilary Cottam and asset-based community development. Cottam (2018) argues that public services should work *with* people, not do things to them, and should draw on a wide range of assets in improving outcomes. Her insights are especially relevant at a time when long-term conditions represent a growing proportion of need and demand, and where there is evidence of the benefits that result when people with these conditions are supported to take greater responsibility for managing them (Coulter *et al* 2013).

Cottam summarises her argument as follows:

*The challenges we face today – whether new challenges like chronic disease or older challenges that have taken on new form, such as finding good work – are long-term and continuous. These are not one-off events that can be cured by an expert or a process that is done to us. What is common to these modern problems is that the solutions require our participation. Whether we think about diabetes or climate change, good ageing or good education, we have to be active agents of change. Solutions require us – communities, the state, business and citizens – to work together, drawing on new ideas and above all on each other to create change.*

(Cottam 2018, pp 32–33)

Areas like Wigan that have adopted such an approach have shown that it is possible to improve population health by working with a range of agencies and engaging local people (Naylor and Wellings 2019).

As this happens, the goal should be to promote shared responsibility for health and wellbeing. Shared responsibility is quite different from personal responsibility, which has been criticised for not recognising that people's behaviours are influenced by the environment in which they live and work. Government must create the conditions in which people can thrive through regulation, taxation, legislation and other means, and this should go hand-in-hand with work to support people to play their part more effectively. Changes in behaviour and interventionist approaches are two sides of the same coin.

Crucially, there must be recognition – as Don Berwick has argued in the United States context – that claims to increase health care spending may result in 'the confiscation by health care of opportunities for growth and success in other sectors' (Berwick 2014). Placing 'improving health' at the heart of the purpose of the NHS is essential to secure its future as part of a cross-government strategy drawing on the work of Michael Marmot and others (Marmot et al 2020). Allocating scarce public resources to services and interventions that will achieve this aim – for example, in the early years – must be the priority.

# References

- Abel J, Kingston H, Scally A, Hartnoll J, Hannam G, Thomson-Moore A, Kellehear A (2018). 'Reducing emergency hospital admissions: a population health complex intervention of an enhanced model of primary care and compassionate communities'. *British Journal of General Practice*, vol 68, no 676, pp e803–10. Available at: <https://bjgp.org/content/68/676/e803> (accessed on 13 February 2023).
- Alderwick H, Dunn P, McKenna H, Walsh N, Ham C (2016). *Sustainability and transformation plans in the NHS: how are they being developed in practice?* London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/stps-in-the-nhs](http://www.kingsfund.org.uk/publications/stps-in-the-nhs) (accessed on 13 February 2023).
- Anandaciva S, Ward D (2019). *How is the NHS performing? July 2019 quarterly monitoring report*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/how-nhs-performing-july-2019](http://www.kingsfund.org.uk/publications/how-nhs-performing-july-2019) (accessed on 13 February 2023).
- Anderson H (2023). 'NHSE "mistaken" in prioritising "headline funding", says ex-Treasury mandarin'. *Health Service Journal* website, 20 January. Available at: [www.hsj.co.uk/finance-and-efficiency/nhse-mistaken-in-prioritising-headline-funding-says-ex-treasury-mandarin/7034081.article](http://www.hsj.co.uk/finance-and-efficiency/nhse-mistaken-in-prioritising-headline-funding-says-ex-treasury-mandarin/7034081.article) (£) (accessed on 20 February 2023).
- Anderson M, Pitchforth E, Asaria M, Brayne C, Casadei B, Charlesworth A, Coulter A, Franklin BD, Donaldson C, Drummond M, Dunnell K, Foster M, Hussey R, Johnson P, Johnston-Webber C, Knapp M, Lavery G, Longley M, Clark JM, Majeed A, McKee M, Newton JN, O'Neill C, Raine R, Richards M, Sheikh A, Smith P, Street A, Taylor D, Watt RG, Whyte M, Woods M, McGuire A, Mossialos E (2021). 'LSE–Lancet Commission on the future of the NHS: re-laying the foundations for an equitable and efficient health and care service after COVID-19'. *The Lancet*, vol 397, no 10288, pp 1915–78. Available at: [www.thelancet.com/article/S0140-6736\(21\)00232-4/fulltext](http://www.thelancet.com/article/S0140-6736(21)00232-4/fulltext) (accessed on 21 December 2022).
- Appleby J, Baird B, Thompson J, Jabal J (2015a). *The NHS under the coalition government. Part two: NHS performance*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/nhs-performance-under-coalition-government](http://www.kingsfund.org.uk/publications/nhs-performance-under-coalition-government) (accessed on 21 December 2022).
- Appleby J, Gainsbury S (2022). 'The past, present and future of government spending on the NHS'. Blog, 17 October. Nuffield Trust website. Available at: [www.nuffieldtrust.org.uk/news-item/the-past-present-and-future-of-government-spending-on-the-nhs](http://www.nuffieldtrust.org.uk/news-item/the-past-present-and-future-of-government-spending-on-the-nhs) (accessed on 13 February 2023).
- Appleby J, Galea A, Murray R (2014a). *The NHS productivity challenge: experience from the front line*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/nhs-productivity-challenge](http://www.kingsfund.org.uk/publications/nhs-productivity-challenge) (accessed on 21 December 2022).

Appleby J, Thompson J, Jabbal J (2016). *How is the NHS performing?* Quarterly monitoring report (QMR) 19. London: The King's Fund. Available at: <https://qmr.kingsfund.org.uk/2016/19/> (accessed on 7 February 2023).

Appleby J, Thompson J, Jabbal J (2015b). *How is the NHS performing?* Quarterly monitoring report (QMR) 16. London: The King's Fund. Available at: <https://qmr.kingsfund.org.uk/2015/16/> (accessed on 3 January 2023).

Appleby J, Thompson J, Jabbal J (2014b). *How is the NHS performing?* Quarterly monitoring report (QMR) 13. London: The King's Fund. Available at: <https://qmr.kingsfund.org.uk/2014/13/> (accessed on 3 January 2023).

Baker C (2022). *NHS key statistics: England, November* [online]. Research briefing. House of Commons Library website. Available at: <https://commonslibrary.parliament.uk/research-briefings/cbp-7281/> (accessed on 20 February 2023).

Barr B, Higginson J, Whitehead M (2017). 'Investigating the impact of the English health inequalities strategy: time trend analysis'. *BMJ*, vol 358. Available at: [www.bmj.com/content/358/bmj.j3310](http://www.bmj.com/content/358/bmj.j3310) (accessed on 21 December 2022).

Beech J, Bottery S, Charlesworth A, Evans H, Gershlick B, Hemmings N, Imison C, Kahtan P, McKenna H, Murray R, Palmer B (2019). *Closing the gap: key areas for action on the health and care workforce* [online]. The King's Fund website. Available at: [www.kingsfund.org.uk/publications/closing-gap-health-care-workforce](http://www.kingsfund.org.uk/publications/closing-gap-health-care-workforce) (accessed on 1 February 2023).

Bennett L, Humphries R (2014). *Making best use of the Better Care Fund: spending to save?* [online]. The King's Fund website. Available at: [www.kingsfund.org.uk/publications/making-best-use-better-care-fund](http://www.kingsfund.org.uk/publications/making-best-use-better-care-fund) (accessed on 21 December 2022).

Berwick D (2014). 'Reshaping US health care: from competition and confiscation to cooperation and mobilization'. *JAMA*, vol 312, no 20, pp 2099–2100.

Blythe N, Ross S (2022). *Strategies to reduce waiting times for elective care* [online]. The King's Fund website. Available at: [www.kingsfund.org.uk/publications/strategies-reduce-waiting-times-elective-care](http://www.kingsfund.org.uk/publications/strategies-reduce-waiting-times-elective-care) (accessed on 21 December 2022).

Bottery S, Varrow M, Thorlby R, Wellings D (2018). *A fork in the road: next steps for social care funding reform*. London: The Health Foundation and The King's Fund. Available at: [www.kingsfund.org.uk/publications/fork-road-social-care-funding-reform](http://www.kingsfund.org.uk/publications/fork-road-social-care-funding-reform) (accessed on 6 February 2023).

Buck D, Baylis A, Dougall D, Robertson R (2018). *A vision for population health: towards a healthier future*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/vision-population-health](http://www.kingsfund.org.uk/publications/vision-population-health) (accessed on 21 December 2022).

Burn-Murdoch J (2022a). 'Britain's winter of discontent is the inevitable result of austerity'. *Financial Times*, 23 December. Available at: [www.ft.com/content/b2154c20-c9d0-4209-9a47-95d114d31f2b](http://www.ft.com/content/b2154c20-c9d0-4209-9a47-95d114d31f2b) (£) (accessed on 11 January 2023).

Burn-Murdoch J (2022b). 'Chronic illness makes UK workforce the sickest in developed world'. *Financial Times*, 21 July. Available at: [www.ft.com/content/c333a6d8-0a56-488c-aeb8-eeb1c05a34d2](https://www.ft.com/content/c333a6d8-0a56-488c-aeb8-eeb1c05a34d2) (£) (accessed on 23 January 2023).

Burn-Murdoch J (2022c). 'How to fix Britain's chronically ill healthcare system'. *Financial Times*, 3 June. Available at: [www.ft.com/content/2f1d62ee-bc1b-4eae-bebd-f4e32076bcd5](https://www.ft.com/content/2f1d62ee-bc1b-4eae-bebd-f4e32076bcd5) (£) (accessed on 21 December 2022).

Buzelli L, Cameron G, Duxbury K, Gardner T, Rutherford S, Williamson S, Alderwick H (2022). *Public perceptions of health and social care: what the new government should know*. London: The Health Foundation. Available at: <https://reader.health.org.uk/what-the-new-government-should-know> (accessed on 21 December 2022).

Cameron D (2019). *For the record*. London: William Collins.

Campbell D (2015). 'Former NHS boss pours cold water on party leaders' election pledges'. *The Guardian*, 16 April. Available at: [www.theguardian.com/society/2015/apr/16/former-nhs-boss-pours-cold-water-on-party-leaders-election-pledges](https://www.theguardian.com/society/2015/apr/16/former-nhs-boss-pours-cold-water-on-party-leaders-election-pledges) (accessed on 21 December 2022).

Care Quality Commission (2019). *The state of health care and adult social care in England 2018/19* [online]. HC 9. CQC website. Available at: [www.cqc.org.uk/sites/default/files/20191015b\\_stateofcare1819\\_fullreport.pdf](https://www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf) (accessed on 21 December 2022).

Care Quality Commission (2017). *The state of health care and adult social care in England 2016/17* [online]. HC 377. CQC website. Available at: [www.cqc.org.uk/sites/default/files/20171123\\_stateofcare1617\\_report.pdf](https://www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf) (accessed on 21 December 2022).

Care Quality Commission (2016). *The state of health care and adult social care in England 2015/16* [online]. HC 706. CQC website. Available at: [www.cqc.org.uk/sites/default/files/20161019\\_stateofcare1516\\_web.pdf](https://www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf) (accessed on 21 December 2022).

Cecil N (2019). 'Britain has delayed plans to deal with adult social care crisis, minister admits'. *Evening Standard*, 12 February. Available at: [www.standard.co.uk/news/politics/brexit-has-delayed-plans-to-deal-with-adult-social-care-crisis-minister-admits-a4064436.html](https://www.standard.co.uk/news/politics/brexit-has-delayed-plans-to-deal-with-adult-social-care-crisis-minister-admits-a4064436.html) (accessed on 21 December 2022).

Cottam H (2018). *Radical help: how we can remake the relationships between us and revolutionise the welfare state*. London: Virago Press.

Coulter A, Roberts S, Dixon A (2013). *Delivering better services for people with long-term conditions: building the house of care* [online]. The King's Fund website. Available at: [www.kingsfund.org.uk/publications/delivering-better-services-people-long-term-conditions](https://www.kingsfund.org.uk/publications/delivering-better-services-people-long-term-conditions) (accessed on 23 January 2023).

Davies N, Hoddinott S, Fright M, Nye P, Pope T, Shepley P, Richards G (2022). *Performance tracker 2022: public services after two years of Covid*. London: Institute for Government. Available at: [www.instituteforgovernment.org.uk/sites/default/files/publications/performance-tracker-2022.pdf](https://www.instituteforgovernment.org.uk/sites/default/files/publications/performance-tracker-2022.pdf) (accessed on 21 December 2022).



Davis K, Schoen C, Stremikis K (2010). *Mirror, mirror: how the performance of the US health care system compares internationally, 2010 update* [online]. The Commonwealth Fund website. Available at: [www.commonwealthfund.org/publications/fund-reports/2010/jun/mirror-mirror-wall-how-performance-us-health-care-system](http://www.commonwealthfund.org/publications/fund-reports/2010/jun/mirror-mirror-wall-how-performance-us-health-care-system) (accessed on 20 February 2023).

Dayan M, Ward D, Gardner T, Kelly E (2018). *How good is the NHS?* London: The Health Foundation, the Institute for Fiscal Studies, The King's Fund, Nuffield Trust. Available at: [www.kingsfund.org.uk/publications/nhs-70-how-good-is-the-nhs](http://www.kingsfund.org.uk/publications/nhs-70-how-good-is-the-nhs) (accessed on 21 December 2022).

Deeny S, Thorlby R, Steventon A (2018). *Reducing emergency admissions: unlocking the potential of people to better manage their long-term conditions*. London: The Health Foundation. Available at: [www.health.org.uk/publications/reducing-emergency-admissions-unlocking-the-potential-of-people-to-better-manage-their-long-term-conditions](http://www.health.org.uk/publications/reducing-emergency-admissions-unlocking-the-potential-of-people-to-better-manage-their-long-term-conditions) (accessed on 23 January 2023).

Department of Health and Social Care (2021). *People at the heart of care: adult social care reform White Paper* [online]. GOV.UK website. Available at: [www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper](http://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper) (accessed on 20 February 2023).

Department of Health and Social Care and NHS England (2023). *Delivery plan for recovering urgent and emergency care services*. London: NHS England. Available at: [www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/](http://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/) (accessed on 1 February 2023).

Everest G, Marshall L, Fraser C, Briggs A (2022). *Addressing the leading risk factors for ill health: a review of government policies tackling smoking, poor diet, physical inactivity and harmful alcohol use in England*. London: The Health Foundation. Available at: [www.health.org.uk/publications/reports/addressing-the-leading-risk-factors-for-ill-health](http://www.health.org.uk/publications/reports/addressing-the-leading-risk-factors-for-ill-health) (accessed on 2 February 2023).

Finch D (2022). *Public health grant: what it is and why greater investment is needed*. London: The Health Foundation. Available at: [www.health.org.uk/news-and-comment/charts-and-infographics/public-health-grant-what-it-is-and-why-greater-investment-is-needed](http://www.health.org.uk/news-and-comment/charts-and-infographics/public-health-grant-what-it-is-and-why-greater-investment-is-needed) (accessed on 21 December 2022).

Fitzpatrick J, Roberts N (2021). 'What the Health Profile for England shows us about the wider impacts of COVID-19 on health'. Blog. UK Health Security Agency, 15 September. Available at: <https://ukhsa.blog.gov.uk/2021/09/15/what-the-health-profile-for-england-shows-us-about-the-wider-impacts-of-covid-19-on-health/> (accessed on 21 December 2022).

Ham C (2017a). 'Political crisis in the NHS'. *BMJ*, vol 356. Available at: [www.bmj.com/content/356/bmj.j218](http://www.bmj.com/content/356/bmj.j218) (accessed on 21 December 2022).

Ham C (2017b). 'Simon Stevens speaks out over NHS funding'. *BMJ*, vol 359. Available at: [www.bmj.com/content/359/bmj.j5251.full?ijkey=5sJjIYZAjKnmqJu&keytype=ref](http://www.bmj.com/content/359/bmj.j5251.full?ijkey=5sJjIYZAjKnmqJu&keytype=ref) (accessed on 21 December 2022).



Ham C (2014). 'The NHS is at breaking point – hard work and dedication alone won't save it'. *The Guardian* website, 28 June. Available at: [www.theguardian.com/commentisfree/2014/jun/28/nhs-at-breaking-point](http://www.theguardian.com/commentisfree/2014/jun/28/nhs-at-breaking-point) (accessed on 21 December 2022).

Ham C (forthcoming). 'Leadership and governance of the responses to Covid-19 in the UK' in Chambers N (ed), *Research handbook on leadership in healthcare*. Cheltenham UK: Edward Elgar.

Ham C, Charles A, Wellings D (2018). *Shared responsibility for health: the cultural change we need*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/shared-responsibility-health](http://www.kingsfund.org.uk/publications/shared-responsibility-health) (accessed on 13 February 2023).

Harker R (2019). *NHS funding and expenditure* [online]. Research briefing. House of Commons Library website. Available at: <https://researchbriefings.files.parliament.uk/documents/SN00724/SN00724.pdf> (accessed on 20 February 2023).

Haslam D (2022). *Side effects: how our healthcare lost its way – and how we fix it*. London: Atlantic Books.

Hawkes N (2016). 'England's health department avoids breaching budget on "technicality"'. *BMJ*, vol 354. Available at: [www.bmj.com/content/354/bmj.i4083](http://www.bmj.com/content/354/bmj.i4083) (accessed on 11 January 2023).

House of Commons Health and Social Care Committee (2022). *Workforce: recruitment, training and retention in health and social care*. HC 115, third report of session 2022–23. Available at: <https://committees.parliament.uk/publications/23246/documents/171671/default/> (accessed on 6 February 2023).

Humphries R (2022). *Ending the social care crisis: a new road to reform*. Bristol: Policy Press.

Humphries R (2014). 'The Better Care Fund: will the plans work?'. Blog. The King's Fund, 5 November. Available at: [www.kingsfund.org.uk/blog/2014/11/better-care-fund-will-plans-work](http://www.kingsfund.org.uk/blog/2014/11/better-care-fund-will-plans-work) (accessed on 21 December 2022).

Humphries R, Timmins N (2021). *Stories from social care leadership: progress amid pestilence and penury*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/social-care-leadership](http://www.kingsfund.org.uk/publications/social-care-leadership) (accessed on 21 December 2022).

Johnston I (2014). 'NHS faces "managed decline" unless it is properly funded, says health chief'. *Independent*, 13 March. Available at: [www.independent.co.uk/life-style/health-and-families/health-news/nhs-faces-managed-decline-unless-it-is-properly-funded-says-health-chief-9188282.html](http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-faces-managed-decline-unless-it-is-properly-funded-says-health-chief-9188282.html) (accessed on 21 December 2022).

Kraindler J, Gershlick B, Charlesworth A (2019). *Failing to capitalise: capital spending in the NHS*. London: The Health Foundation. Available at: [www.health.org.uk/publications/reports/failing-to-capitalise](http://www.health.org.uk/publications/reports/failing-to-capitalise) (accessed on 4 January 2023).

Lafond S (2015). *Current NHS spending in England*. London: The Health Foundation. Available at: [www.health.org.uk/sites/default/files/FundingOverview\\_CurrentNHSSpendingInEngland.pdf](http://www.health.org.uk/sites/default/files/FundingOverview_CurrentNHSSpendingInEngland.pdf) (accessed on 13 February 2023).

Lee G (2023). 'England's NHS ten times worse than in 2011 on four key measures'. Channel 4 News website. 18 January. Available at: [www.channel4.com/news/factcheck/factcheck-englands-nhs-ten-times-worse-than-in-2011-on-four-key-measures](http://www.channel4.com/news/factcheck/factcheck-englands-nhs-ten-times-worse-than-in-2011-on-four-key-measures) (accessed on 6 February 2023).

Lent A, Pollard G, Studdert J (2022). *A community-powered NHS: making prevention a reality*. London: New Local. Available at: [www.newlocal.org.uk/publications/community-powered-nhs](http://www.newlocal.org.uk/publications/community-powered-nhs) (accessed on 21 December 2022).

Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J (2020). *Health equity in England: the Marmot review 10 years on*. London: The Health Foundation. Available at: [www.health.org.uk/publications/reports/the-marmot-review-10-years-on](http://www.health.org.uk/publications/reports/the-marmot-review-10-years-on) (accessed on 23 January 2023).

McCarey M, Dayan M, Jarman H, Hervey T, Fahy N, Bristow D, Greer SL (2022). *Health and Brexit: six years on*. London: Nuffield Trust. Available at: [www.nuffieldtrust.org.uk/research/health-and-brexit-six-years-on](http://www.nuffieldtrust.org.uk/research/health-and-brexit-six-years-on) (accessed on 20 February 2023).

McDonald S, Grasic K, Tikhonovsky N (2023). 'Are NHS waiting times contributing to excess deaths?'. Blog. London: Covid-19 Actuaries Response Group. Available at: <https://covidactuaries.org/2023/01/11/are-nhs-waiting-times-contributing-to-excess-deaths> (accessed on 23 January 2023).

McKee M, Dunnell K, Anderson M, Brayne C, Charlesworth A, Johnston-Webber C, Knapp M, McGuire A, Newton J, Taylor D, Watt R (2021). 'The changing health needs of the UK population'. *The Lancet*, vol 397, no 10288, pp 1979–91. Available at: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)00229-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00229-4/fulltext) (accessed on 4 January 2023).

Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Chair: Robert Francis)*. London: The Stationery Office. Available at: [www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry](http://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry) (accessed on 14 February 2023).

Morgan B (2022). *NHS staffing shortages: why do politicians struggle to give the NHS the staff it needs?* [online]. The King's Fund website. Available at: [www.kingsfund.org.uk/publications/nhs-staffing-shortages](http://www.kingsfund.org.uk/publications/nhs-staffing-shortages) (accessed on 21 December 2022).

Mulley A, Trimble C, Elwyn G (2012). *Patients' preferences matter: stop the silent misdiagnosis*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/patients-preferences-matter](http://www.kingsfund.org.uk/publications/patients-preferences-matter) (accessed on 23 January 2023).

National Audit Office (2022). *Introducing integrated care systems: joining up local services to improve health outcomes*. London: National Audit Office. Available at: [www.nao.org.uk/reports/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes](http://www.nao.org.uk/reports/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes) (accessed on 21 December 2022).

National Audit Office (2020a). *NHS financial management and sustainability*. HC 44 (2019–20), 5 February 2020. London: National Audit Office. Available at: [www.nao.org.uk/reports/nhs-financial-management-and-sustainability](http://www.nao.org.uk/reports/nhs-financial-management-and-sustainability) (accessed on 10 February 2023).

National Audit Office (2020b). *Review of capital expenditure in the NHS*. HC 43 (2019–20), 5 February 2020. London: National Audit Office. Available at: [www.nao.org.uk/reports/review-of-capital-expenditure-in-the-nhs/](http://www.nao.org.uk/reports/review-of-capital-expenditure-in-the-nhs/) (accessed on 21 December 2022).

National Audit Office (2010). *Management of NHS hospital productivity*. HC 491 (2010–11), 17 December 2010. London: The Stationery Office. Available at: [www.nao.org.uk/reports/management-of-nhs-hospital-productivity/](http://www.nao.org.uk/reports/management-of-nhs-hospital-productivity/) (accessed on 21 December 2022).

Naylor C, Wellings D (2019). *A citizen-led approach to health and care: lessons from the Wigan Deal*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/wigan-deal](http://www.kingsfund.org.uk/publications/wigan-deal) (accessed on 21 December 2022).

NHS Business Services Authority (2009). *Annual report and accounts 2008/09*. London: The Stationery Office. Available at: [www.nhsbsa.nhs.uk/sites/default/files/2017-05/financial-audit-report.pdf](http://www.nhsbsa.nhs.uk/sites/default/files/2017-05/financial-audit-report.pdf) (accessed on 8 March 2023).

NHS England (2019). *The NHS long term plan* [online]. NHS website. Available at: [www.longtermplan.nhs.uk](http://www.longtermplan.nhs.uk) (accessed on 21 December 2022).

NHS England, Care Quality Commission, Health Education England, Monitor, NHS Trust Development Authority, Public Health England (2014). *NHS five year forward view* [online]. London: NHS England. Available at: [www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf) (accessed on 21 December 2022).

Nuffield Trust, The Health Foundation, The King's Fund (2015). *The spending review: what does it mean for health and social care?* [online]. The King's Fund website. Available at: [www.kingsfund.org.uk/publications/spending-review-health-social-care](http://www.kingsfund.org.uk/publications/spending-review-health-social-care) (accessed on 21 December 2022).

OECD (2016). *OECD reviews of health care quality: United Kingdom 2016. Raising standards*. Paris: OECD. Available at: [https://read.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-care-quality-united-kingdom-2016\\_9789264239487-en#page1](https://read.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-care-quality-united-kingdom-2016_9789264239487-en#page1) (accessed on 21 December 2022).

Public Accounts Committee (2023). *Introducing integrated care systems. Thirty-fifth report of session 2022–23*. HC 47. London: House of Commons. Available at: <https://committees.parliament.uk/publications/33872/documents/185310/default/> (accessed on 9 February 2023).

Public Accounts Committee (2011). *Health landscape review* [online]. Oral evidence taken before the Public Accounts Committee, Tuesday 25 January 2011, Una O'Brien and Sir David Nicholson. Parliament UK website. Available at: [www.publications.parliament.uk/pa/cm201011/cmselect/cmpubacc/c764-i/c76401.htm](http://www.publications.parliament.uk/pa/cm201011/cmselect/cmpubacc/c764-i/c76401.htm) (accessed on 21 December 2022).

Rebolledo I, Charlesworth A (2022). *How does UK health spending compare across Europe over the past decade?* London: The Health Foundation. Available at: [www.health.org.uk/news-and-comment/charts-and-infographics/how-does-uk-health-spending-compare-across-europe-over-the-past-decade](http://www.health.org.uk/news-and-comment/charts-and-infographics/how-does-uk-health-spending-compare-across-europe-over-the-past-decade) (accessed on 2 January 2023).

Rees S, Hassan H (2023). *The A&E crisis: what's really driving poor performance?* London: Reform. Available at: <https://reform.uk/publications/the-ae-crisis-whats-really-driving-poor-performance/> (accessed on 10 February 2023).

Schneider E, Shah A, Doty M, Tikkanen R, Fields K, Williams II R (2021). *Mirror, mirror 2021. Reflecting poorly: health care in the US compared to other high-income countries*. New York: The Commonwealth Fund. Available at: [www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly](http://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly) (accessed on 14 February 2023).

Secretary of State for Health (2008). *High quality care for all. NHS next stage review final report*. Cm 7432. London: The Stationery Office. Available at: [www.gov.uk/government/publications/high-quality-care-for-all-nhs-next-stage-review-final-report](http://www.gov.uk/government/publications/high-quality-care-for-all-nhs-next-stage-review-final-report) (accessed on 21 December 2022).

Secretary of State for Health (2000). *The NHS plan: a plan for investment, a plan for reform*. Cm 488-I. London: Department of Health. Available at: [https://webarchive.nationalarchives.gov.uk/ukgwa/+http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh\\_4002960](https://webarchive.nationalarchives.gov.uk/ukgwa/+http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4002960) (accessed on 21 December 2022).

Seddon J (2008). *Systems thinking in the public sector: the failure of the reform regime and a manifesto for a better way*. Axminster: Triarchy Press.

Starmer K (2023). *Keir Starmer new year's speech*. Speech in Stratford, London, 5 January. Available at: <https://labour.org.uk/press/keir-starmer-new-years-speech> (accessed on 12 February 2023).

Steel N, Ford J, Newton J, Davis A, Vos T, Naghavi M, Glenn S, Hughes A, Dalton A, Stockton D, Humphreys C, Dallat M, Schmidt J, Flowers J, Fox S, Abubakar I, Aldridge R, Baker A, Brayne C, Brugha T, Capewell S, Car J, Cooper C, Ezzati M, Fitzpatrick J, Greaves F, Hay R, Hay S, Kee F, Larson H, Lyons R, Majeed A, McKee M, Rawaf S, Rutter H, Saxena S, Sheikh A, Smeeth L, Viner R, Vollset S, Williams H, Wolfe C, Woolf A, Murray C (2018). 'Changes in health in the countries of the UK and 150 English local authority areas 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016'. *The Lancet*, vol 392, pp 1647–61. Available at: [www.thelancet.com/action/showPdf?pii=S0140-6736%2818%2932207-4](http://www.thelancet.com/action/showPdf?pii=S0140-6736%2818%2932207-4) (accessed on 21 December 2022).

Stevens S (2014). Speech in Tyneside, 1 April. Available at: [www.england.nhs.uk/2014/04/simon-stevens-speech/](http://www.england.nhs.uk/2014/04/simon-stevens-speech/) (accessed on 21 December 2022).

Stoye G, Zaranko B (2019). *UK health spending*. London: Institute for Fiscal Studies. Available at: <https://ifs.org.uk/publications/uk-health-spending-0> (accessed on 21 December 2022).

Tallack C, Charlesworth A, Kelly E, McConkey R, Rocks S (2020). *The bigger picture: learning from two decades of changing NHS care in England*. London: The Health Foundation. Available at: [www.health.org.uk/publications/reports/the-bigger-picture](http://www.health.org.uk/publications/reports/the-bigger-picture) (accessed on 21 December 2022).

The Archbishops of Canterbury and York (2023). *Care and support reimagined: a national care covenant for England* [online]. Available at: [www.archbishopofcanterbury.org/news/news-and-statements/care-and-support-reimagined-national-care-covenant-england-0](http://www.archbishopofcanterbury.org/news/news-and-statements/care-and-support-reimagined-national-care-covenant-england-0) (accessed on 14 February 2023).

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Theis D, White M (2021). 'Is obesity policy in England fit for purpose? Analysis of government strategies and policies, 1992–2020'. *The Milbank Quarterly*, vol 99, no 1, pp 126–70.

Available at: <https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-0009.12498> (accessed on 2 February 2023).

Thistlethwaite P (2011). *Integrating health and social care in Torbay: improving care for Mrs Smith*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay](http://www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay) (accessed on 13 February 2023).

Thorlby R, Maybin J (eds) (2010). *A high performing NHS? A review of progress 1997–2010*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/high-performing-nhs](http://www.kingsfund.org.uk/publications/high-performing-nhs) (accessed on 21 December 2022).

Timmins N (2018). 'The world's biggest quango'. *The first five years of NHS England*. London: Institute for Government and The King's Fund. Available at: [www.kingsfund.org.uk/publications/worlds-biggest-quango-nhs-england](http://www.kingsfund.org.uk/publications/worlds-biggest-quango-nhs-england) (accessed on 21 December 2022).

Tinson A, Major A, Finch D (2022). *Is poor health driving a rise in economic inactivity?* London: The Health Foundation. Available at: [www.health.org.uk/news-and-comment/charts-and-infographics/is-poor-health-driving-a-rise-in-economic-inactivity](http://www.health.org.uk/news-and-comment/charts-and-infographics/is-poor-health-driving-a-rise-in-economic-inactivity) (accessed on 13 February 2023).

Wanless D (2002). *Securing our future health: taking a long-term view*. Final report. London: HM Treasury. Available at: [https://improve.bmj.com/improve\\_post/securing-our-future-health-taking-a-long-term-view-final-report/](https://improve.bmj.com/improve_post/securing-our-future-health-taking-a-long-term-view-final-report/) (accessed on 14 February 2023).

Wanless D, Appleby J, Harrison A, Patel D (2007). *Our future health secured? A review of NHS funding and performance*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/our-future-health-secured](http://www.kingsfund.org.uk/publications/our-future-health-secured) (accessed on 21 December 2022).

Warner M, Zaranko B (2022). *NHS funding, resources and treatment volumes*. London: Institute for Fiscal Studies. Available at: <https://ifs.org.uk/publications/nhs-funding-resources-and-treatment-volumes> (accessed on 21 December 2022).

Warren S (2022). 'Austerity 2.0: why it's critical for our health that the government learns the lessons of austerity 1.0'. Blog, 1 November. The King's Fund. Available at: [www.kingsfund.org.uk/blog/2022/11/critical-for-health-government-learns-lessons-austerity](http://www.kingsfund.org.uk/blog/2022/11/critical-for-health-government-learns-lessons-austerity) (accessed on 21 December 2022).

Warren S (2021). 'The recipe for success at the Office for Health Improvement and Disparities: tackling the wider determinants of health'. Blog, 30 September. The King's Fund. Available at: [www.kingsfund.org.uk/blog/2021/09/recipe-success-office-health-improvement-and-disparities](http://www.kingsfund.org.uk/blog/2021/09/recipe-success-office-health-improvement-and-disparities) (accessed on 13 February 2023).

Wellings D, Jefferies D, Maguire D, Appleby J, Hemmings N, Morris J, Schlepper L (2022). *Public satisfaction with the NHS and social care in 2021: results from the British Social Attitudes survey*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/public-satisfaction-nhs-social-care-2021](http://www.kingsfund.org.uk/publications/public-satisfaction-nhs-social-care-2021) (accessed on 21 December 2022).

Whitaker P (2023). 'How to save the NHS'. *New Statesman*, 18 January. Available at: [www.newstatesman.com/politics/health/2023/01/how-to-save-the-nhs](http://www.newstatesman.com/politics/health/2023/01/how-to-save-the-nhs) (accessed on 23 January 2023).

Whitty C (2017). 'Harveian Oration 2017: triumphs and challenges in a world shaped by medicine'. *Clinical Medicine*, vol 17, no 6, pp 537–44. Available at: [www.rcpjournals.org/content/clinmedicine/17/6/537/tab-figures-data](http://www.rcpjournals.org/content/clinmedicine/17/6/537/tab-figures-data) (accessed on 13 February 2023).

Zaranko B (2021). 'An ever-growing NHS budget could swallow up all of this week's tax rise, leaving little for social care'. IFS website, 8 September. Available at: <https://ifs.org.uk/articles/ever-growing-nhs-budget-could-swallow-all-weeks-tax-rise-leaving-little-social-care> (accessed on 13 February 2023).

Zaranko B (2020). *Spending review 2020: Covid-19, Brexit and beyond*. London: Institute for Fiscal Studies. Available at: <https://ifs.org.uk/books/spending-review-2020-covid-19-brexit-and-beyond> (accessed on 17 January 2023).

# Acknowledgements

I had two motivations in writing this report. The first was to set out to chart the decline of the NHS between 2010 and 2020, drawing on various sources from The King's Fund and other organisations. The second was to identify lessons for politicians and policy-makers facing the challenge of deciding what to do next. I sought comments from a number of those involved in senior leadership roles during that period, some of whom prefer to remain anonymous.

I am grateful for comments on earlier drafts from John Appleby, Richard Douglas, Chris Hopson, Richard Humphries, David Nicholson, Simon Stevens and Nick Timmins. At The King's Fund I received valuable feedback from Siva Anandaciva, Alex Baylis, Richard Murray and Sally Warren. I alone am responsible for any errors or omissions.



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Chris has authored more than 20 books and numerous articles on health policy and management. During his career, he has worked at the universities of Leeds, Bristol and Birmingham, from where he was seconded to the Department of Health to work as the Director of the Strategy Unit between 2000 and 2004. He works at the interface between research and policy, drawing on evidence to inform decision-making.

From 2019 to 2021, Chris was chair of the Coventry and Warwickshire Integrated Care System and non-executive director of the Royal Free London NHS Foundation Trust.

Chris has advised the World Bank and the World Health Organization, as well as the governments of New Zealand and Sweden. He has served as an adviser in the UK to the Audit Commission, the House of Commons Health Committee and the National Audit Office.

He has also been a board member of the Canadian Health Services Research Foundation and the Canadian Institutes of Health Research. He was visiting professor at the University of Toronto in 2019.

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Chris was awarded a CBE for his services to the NHS in 2004 and a knighthood for services to health policy and management in 2018. He was made an honorary fellow of the Royal College of Physicians of London in 2004 and an honorary fellow of the Royal College of General Practitioners in 2008. He became a companion of the Institute of Healthcare Management in 2006.



**Published by**

The King's Fund  
11-13 Cavendish Square  
London W1G 0AN  
Tel: 020 7307 2568

Email: [publications@kingsfund.org.uk](mailto:publications@kingsfund.org.uk)

[www.kingsfund.org.uk](http://www.kingsfund.org.uk)

© The King's Fund 2023

First published 2023  
by The King's Fund

Charity registration number:  
1126980

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Edited by Kathryn O'Neill

Typeset by  
Grasshopper Design Company,  
[www.grasshopperdesign.net](http://www.grasshopperdesign.net)

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