The crisis of the UK National Health Service (NHS)

The imperative of dealing with legacy issues from the past

CONTENTS

Abstract

At various times in the past, the UK National Health Service (NHS) was often referred to as being the “envy of the world. This is true no longer and the NHS is now seen as being in severe crisis with a number of serious problems including lack of access, long waiting times, staff shortages and service inequalities.

In the 78 years the NHS has existed there have been numerous attempts at reform in order to alleviate these problems. One source suggests there have been 65 attempts at reform since 1948 and the current government is has recently published the fourth “long term” plan for the NHS, in recent memory.

However, all these attempts at reform seem, merely, to have “papered over” fundamental problems. This paper argues that the problems of the NHS derive from errors and compromises made at the time of its inception in 1948 which have never been resolved. These are seen as concerning.

- Financing of the NHS
- Primary health care organisation
- Health and social care integration
- Focus on preventative health care.
- Over-Centralisation

The paper argues that it is only by addressing these legacy issues will the ongoing problems of the NHS be resolved. However, the dysfunctional nature of UK governments is such that it makes it extremely difficult to implement such reforms which require radical changes to be made.

Introduction

The UK National Health Service (NHS) was established in 1948 as a universal healthcare system with comprehensive health service provision free at the point of receipt. Each year many millions of patients receive good or very good care at various levels in the NHS. However, all is not well. While we still see world class care in many settings, at the current time, the NHS is seen as being in crisis with a number of serious problems existing, including the following:

- **Access** – access to primary health care in the community should be easily available but in many UK areas it is increasingly difficult to get doctors' appointments (Which 2023). Emergency departments in hospitals always have their doors open but patients can wait many hours to have their problems attended to. (ONS 2024)
- **Waiting times** – in 2023, a record 7.47 million people were waiting for routine hospital treatment (BBC 2023), This is the highest number since records began for the NHS in England, in 2007. Some 385,000 people have been waiting more than a year to start treatment. The present government have made some improvements in this area, but it is still a major issue.
- **Staff shortages** - The NHS workforce is huge and growing, but not rapidly enough to keep pace with demand for NHS services which has been growing faster. Vacancies remain a big concern, with hundreds of thousands of posts unfilled on a substantive basis.
- **Health system interface problems** – a common criticism made of the NHS is a lack of effective interfaces between the different parts of the health system (Griffiths 2024). For example, a patient may receive excellent care in a tertiary care hospital but, on discharge, the interface between that hospital and secondary or primary care may be lacking.
- **Technology and systems** – in the modern NHS, having a robust and coordinated IT infrastructure is essential for good patient care and efficiency. However, there is considerable amount of evidence (Zhang 2022) which suggests that "there is a growing disconnect between government messages promoting a digital future for healthcare (including artificial intelligence) and the lived experience of clinical staff coping daily with ongoing IT problems".
- **Funding shortfalls** – the NHS managed to overspend against its funding allocation in its first year of existence. In its first year the NHS cost £248m to run, almost £140m more than had been originally estimated (Tweddell 2008). In 2022 The Kings Fund (2022) published a document entitled "The rise and

decline of the NHS in England 2000-2020" again reflecting the lack of sufficient funding. Fast forward to 2023, where the Financial Times (2023) reported that NHS leaders, believed the NHS was facing the worst crisis in its history as a consequence of funding shortfalls. This picture suggests that, apart from a few years in the early 2000s, the funding model for the NHS has always been insufficient to deliver against expectations.

Taken together, these are an alarming set of problems but how did we get to this situation and what should be done about it. At various times in the past, the NHS was often referred to as being the "envy of the world". Perhaps this was always a case of hyperbole but certainly it is not the case today. Table 1 shows the quality of health care for each of the G7 countries where the UK sits at the bottom although it sits nowhere near the bottom in terms of prosperity as measured by country GDP/ capita.

TABLE 1: HEALTH CARE QUALITY AND PROSPERITY

	Healthcare quality			Prosperity		
Rank	**Country**	**Healthcare quality**		**Rank**	**Country**	**GDP/Capita**
1	Canada	71.3		1	USA	90
2	Germany	64.7		2	Germany	58
3	Japan	59.5		3	Canada	56
4	USA	56.7		4	UK	55
5	Italy	49.6		5	France	50
6	France	48.3		6	Italy	41
7	UK	47.1		7	Japan	36

Various Sources

Over the years, there has been no shortage of attempts at changing or reforming the NHS in order to make improvements and overcome the challenges. For decades after the NHS was created, there were numerous attempts at this. A report from the Nuffield Trust (u/d) indicated that between 1950 and 2015, there were an astonishing 65 "initiatives" that took place in the NHS with the aim of improving its performance. However, in spite of all this amount of change that has taken place, none of these have really solved the underlying problems referred to above.

In recent years, there have been four "long term" plans for the NHS. These documents were designed as comprehensive, 5-to-10-year roadmaps for the entire service:

- **The NHS Plan (2000):** Often seen as the first "modern" long-term strategy. Launched under Tony Blair, it was a 10-year plan focused on massive investment, increasing clinical staff and reducing waiting times through strict national targets.

- **The Five-Year Forward View (2014):** Introduced by Simon Stevens (then CEO of NHS England), this plan shifted the focus toward "integrated care." It moved away from the competition-based model of the early 2010s and emphasized prevention and breaking down the barriers between GPs and hospitals.
- **The NHS Long Term Plan (2019):** A 10-year strategy that built on the 2014 plan. It aimed to make the NHS "fit for the future" by digitizing services (like the NHS App), boosting out-of-hospital care, and focusing on major killers like cancer and heart disease.
- **Fit for the Future: 10 Year Health Plan (2025):** The most recent major strategy, launched by the current Labour government. It focuses on "three shifts": moving from hospital to community care, from analogue to digital, and from treatment to prevention.

Almost, by definition, the first three plans must have failed since new plans were produced to replace them. This doesn't mean they had no impact but that they were not real comprehensive plans designed to ensure all the ailments of the service were resolved.

The 2025 plan is very new and in summary the key points of emphasis of this plan are (NHS Confederation 2025):

- A shift to digitisation in the delivery of health care
- A focus on preventative health care
- A shift from hospital care to community-based care
- Establishment of a Neighbourhood Health Service
- Reform of the NHS operating model

While these are laudable objectives, they are, largely, not new and have been advocated in many quarters with some already having been covered in this paper. However, the general consensus about this ten-year plan is that it lacked detail about how the changes proposed are to be implemented and funded (Smith 2025, BMJ 2025). Furthermore, as noted in this paper, it failed to address the thorny issues, discussed later, of obtaining sustainable health funding and on a top down highly centralised model.

Root causes of current situation

Created in 1948, the NHS was, rightly, based on need, not wealth, and it replaced the patchwork system that existed previously across the country. It was an amazing achievement against huge resistance. The first Minister of Health (Aneurin Bevan), according to his biographer (Thomas Symonds 2014), found it was not an easy task. There were many difficulties to be overcome, and compromises had to be made. At one point it seemed likely that the whole thing would fall apart before it was created.

In considering what had gone wrong and what sort of improvements are needed, one should reflect on the decisions made at the time the NHS was formed and some of the compromises that also had to be made. Such decisions and compromises created problems, which haunt us to this day. The first issue concerned lack of knowledge. At the time the NHS was formed, the prevailing wisdom about demands for health care seemed to be something like this. There is a pool of sickness and ill-health in the country and so if we pour some resources into improving health care that pool of sickness will decline and demands for healthcare will stabilise, as will demands for financial resources. This, of course, was a myth and what was not considered was the impact of two phenomena.

- **The ageing population** - the increasing numbers of elderly people in the population (consequent on medical science developments) meant that increased numbers of elderly people required more health (and social) care than the rest of the population.
- **Medical science developments** – over many years there have been many medical scientific and technological developments which required funding. Examples are diagnostics, (CT scans, MRI scans etc), surgical (joint replacements, organ transplants etc) and medications (anti-biotics, anti-viral medicines etc)

The second issue was basically to do with compromises that had to be made to get the NHS formed. A major issue was that Aneurin Bevan was forced to make compromises with the medical profession to get the NHS created. He agreed that they could work full time for the NHS with protected time for their private work using ‘private’ beds and resources in NHS hospitals. However, he was also forced to compromise on the key issue of how primary medical care would be organised in terms of GPs being independent contractors working for the NHS on contract and not paid employees. Not surprisingly, Bevan took the view that it was better to have an NHS with major flaws than not have an NHS at all.

As a consequence of these decisions, I believe there are five legacy issues that can be identified concerning the following.

- Financing the NHS
- Primary health care organisation
- Health and social care integration
- Focus on preventative health care.
- Over-Centralisation

In the light of the above, and the failure of the many previous attempts to reform the NHS, the only feasible course of action seems to be a major set of fundamental reforms of the NHS (and associated organisations, including its relationships with government) based on all of these five issues. While each of these five issues are very significant in their own right, they are also inextricably linked with one another. Unfortunately, the NHS has a history of piecemeal implementation and hence, for a successful outcome, there must be some degree of coordination regarding actions in relation to these five issues. Each of these five issues are complex in their own right and this paper can only discuss some of the key points in each case.

However, there is something more substantial. This is the dysfunctionality of UK government with its vast over-centralisation (Prowle etc 2023). One author (Hudson 2019) was quoted as saying ". the currency of modern (UK) politics seems to be squarely that of failure – indeed major failure". Many, other similar views can be quoted but nothing seems to change. The UK remains perhaps the most centralised developed state in the world with an increasing consensus of this creating severely dysfunctional government in the UK (IEA 2025, Smith 2025, Richards et al 2024). In turn, this dysfunctionality impacts on the NHS and other public services.

In the light of this, how can these changes to the NHS be achievable within the existing highly centralised command and control system of UK government. It is important to emphasise that this is a political and not a technical barrier.

Financing the NHS

At the start of the NHS, a decision was made to establish an NHS which was controlled, from the centre, by the UK government, as opposed to an alternative arrangement of placing health under the control of local government with localised sources of finance. Inevitably, this centralised approach meant that the NHS would largely be funded from centrally collected tax revenues rather than some form of localised finance. As a consequence of this, funding decisions of the NHS became part of the larger governmental decision-making process by means of which government allocates funds to all public expenditure programmes.

One reason for this decision to centralise was to try and ensure the same standards of health service provision across the UK. While a laudable aim, this policy failed. Decades later the NHS is nowhere near achieving that ideal of uniformity of service and the reality is that the centrally controlled NHS shows large healthcare variations of many kinds across the UK, resulting in, notably different life expectancies.

Existing Funding Approach

The process for funding the NHS is just part of the process by means of which governments decide how to allocate funds to the wide range of public services. This process is complex, and the details change over time but the basic aspects concern balancing the funds available to government with the funds needed to deliver public services and can be described as below.

1. Forecast the likely revenues that will be received by the government, in the year ahead, from various sorts of taxation and other forms of revenue such as charges.
2. Government departments (including health) make estimates of what funds they will require to deliver the wide range of public services in the light of changes in need and other factors.
3. When these estimates of government revenues, and expenditure requirements from all government programmes are compared, it is almost inevitable that the demands for funding will exceed that likely to be available.
4. In some circumstances, governments may decide to borrow money to fund the gap but, over many years, this has led to a situation where the UK had alarming levels of public debt and so future borrowing is likely to be limited. Indeed, governments today talk about paying off some of this debt, but this also seems difficult to achieve.

5. There then follows a complex and time-consuming process of negotiation between the Treasury (Finance Ministry) and spending departments about the funds to be made available for a particular spending programme (e.g. health). This may or may not go smoothly and sometimes resort has had to be made to some form of arbitration mechanisms.

It is clear from this that the NHS as a public expenditure programme is essentially competing for financial resources with other public expenditure programmes. Now while this process will undoubtedly make use of data, and an analysis of needs, and gaps in service, across all public services, the decision making is rather opaque. Pressure groups, political issues and other factors will have an influence on funding levels as well as data and scientific evidence. This has always been an issue for all UK governments.

Funding and expenditure pressures

The need for NHS resources is driven by a number of key factors such as population size/structure, morbidity levels, socio-economic factors and the availability of medical science and technology developments.

Since the NHS was created in 1948, funding has risen by an average of 3.4% (Health Foundation 2024). However, this pattern of annual funding growth has varied enormously and over the life of the NHS as shown in the table 2 below.

TABLE 2: NHS FUNDING GROWTH

Period	Average Annual Growth in real terms	Comment
2005-2010	-5.5% to + 6.3%	Period of high investment under the Labour government.
2010-2019	-1.1% to + 1.5%	Austerity" period following the 2008 financial crisis; lowest growth decade in NHS history
2020-2022	-10.0% to + 26.0%	Massive spike due to emergency COVID-19 pandemic funding.
2022-2024	-3.0% to -8.0%	Real-terms contraction as emergency COVID funding was withdrawn.
2024-2025	-3.5% to +5.0%	Uplift following the 2024 General Election and 2025 Budget/Spring Statement.

The NHS has often struggled to work within the financial resources provided to it by this process. Over a period of years, there have been a series of financial crises in the NHS followed by a short-term burst of funding to stabilise the situation. The

whole cycle is then repeated a few years later. This is illustrated in table 3 below for the NHS in England.

TABLE 3: FINANCIAL PERFORMANCE OF THE NHS

Period	Financial Performance
2005/06 to 2006/07	In this period the NHS faced its first significant financial deficits with a deficit of £547 million by 2005/06. These deficits continued into 2006/07, where the total deficit was estimated at around £500 million.
2015/16	This year marked a particularly challenging period for the NHS. It experienced a significant financial deficit, with a total shortfall of £2.45 billion in England. This was the highest deficit in NHS history at the time, attributed to rising patient demand, workforce shortages, and insufficient funding.
2016/17	The financial deficit continued in 2016/17, with a deficit of £791 million. However, this was a significant improvement compared to 2015/16, indicating some stabilization after the previous year's crisis.
2017/18	Despite efforts to improve the NHS's financial performance, deficits persisted in 2017/18, reaching a total of £960 million across England
2018/19	The financial deficit continued, but again, it was somewhat reduced compared to earlier years. The NHS reported a deficit of £1 billion by the end of the year, mainly driven by challenges with increased demand for services and rising healthcare costs.
2019/20	The NHS ended the financial year with a reported deficit of £1.8 billion, due to a variety of factors, including increased patient demand, staffing issues, and delayed savings initiatives.
2020/21	While the NHS's deficit in the 2020/21 financial year was somewhat different due to the extraordinary circumstances of the COVID-19 pandemic, there were still significant financial challenges, though many of the normal budget constraints were temporarily eased by government support and emergency funding during the pandemic.

2021/22	Financial deficits continued to challenge the NHS as it dealt with the long-term impacts of COVID-19. The NHS recorded deficits of about £1 billion by the end of the year, with costs rising due to backlog treatment needs and a larger workforce requirement to tackle the ongoing healthcare crisis.

It can be seen that the NHS has faced significant financial pressure during many periods, largely due to increasing demand for services, rising costs, and limited government funding increases relative to the rate of inflation and population growth.

Such big variations in NHS financial growth each year must imply that its annual funding is not based purely on the need for services but must include a host of other factors including, service shortfalls, political priorities and public perceptions which must come into this.

This lack of transparency in how health services are funded is damaging to democracy particularly in the current volatile political environment. Also, these sharp changes in the level of NHS funding are not conducive to good management and transparency. In the period under the Blair/Brown governments, the NHS received increases which were significantly higher than had been received in previous decades. However, subsequently, criticisms were made about the way in which the additional funds were used and whether it was an effective and efficient use of resources (Cookson et al, 2012).

The conclusion must be that this approach to funding health services is chaotic and does nothing to help the NHS get a grip on the problems facing it. Something must change.

An Alternative Approach – hypothecated taxation

Unlike income tax and VAT which are general taxes which go into a central pool of tax revenues, a hypothecated tax is one where the revenue from a specific tax is dedicated or earmarked to a particular expenditure purpose. In the UK, the best example of a hypothecated tax is that of National Insurance Fund where the revenues received are earmarked largely for the payment of social welfare benefits.

Hence, the issue arises whereby the NHS might be financed through a separate hypothecated tax to fund health services. Hypothecated taxes already exist in many other countries are used to finance health programmes. Such taxes have a number of advantages including the following (Doetinchem, 2010)

- Improved accountability for tax revenues -taxpayers know where their money is going.
- Transparency – people can see where and how their tax revenues are being spent which is not the case with general taxes.
- Public support – politicians tend to believe (and they may be correct) that voters are resistant to increases in general taxation. However, polls do suggest that people would be more open to paying more tax which is hypothecated for health services than they would for increases in general taxation (Kings Fund 2018).
- Protecting resources - a way to ring-fence resources from competing political interests and a way to by-pass budgetary constraints mandated by ministries of finance

Now, of course, there are some disadvantages to hypothecated taxation such as the volatility of revenue streams (Keable-Elliot 2014, Seeley 2011) but these are technical issues which can largely be overcome if there is a will to do so, Moreover, the existing financial arrangements for the NHS seem to be unsustainable and so something different must be considered. The UK could move to a hypothecated health tax similar to a statutory health insurance (SHI) model (with earnings related contributions from all), perhaps based on the German system. In Germany the SHI contribution rate is 14.6% of gross income and so contributions are based on an individual's income. If it works in Germany, why should it not work in the UK?

However, what must be recognised that the introduction of a form of hypothecated taxation to finance the NHS will be fiercely resisted by national politicians and civil service. I have already emphasised the over-centralisation of UK government and introducing such a hypothecated tax would be seen as taking power away from the centre of government and creating a clear link between taxation levels and service.

Primary Health Care Organisation

Primary health care services are often termed the 'front door' of the NHS being the main way that people access NHS services. There are four main services via general medical practices, dental practices, optometrists (eye care) and community pharmacies. Primary care services account for a large proportion of NHS service providers – for example, there are more than 11,000 pharmacies across England, compared with fewer than 200 accident and emergency departments.

Unlike secondary care providers (such as acute hospitals) that are run directly by the NHS, it is not always realised that most primary care practitioners are not employees of the NHS but private practitioners working on contract to the NHS for the delivery of services. This was an outcome, referred to earlier, of the compromises made, by Aneurin Bevan at the time of the formation of the NHS.

Regarding primary medical care, many would argue, (and to a degree they would be right) that this model of primary care medicine has worked well (NHS Networks 2023). However, I would suggest that there is evidence that this model of primary care is not now fit for purpose in the present age. There are a number of aspects to this including:

- Around 10% of GP practices are still single handed (down significantly over the years) but these single-handed practices tend to be in economically deprived areas (NHS Foundation 2020) and struggle to provide the level of care needed.
- Many GP practices are still too small and/or too limited in the services they provide. This is what causes so many problems for the secondary hospital system who have to provide such services.
- The funding mechanism of contract payments for services is wasteful and does not foster desired changes in the pattern of services.
- In an organisation like the NHS, there is often a need to be able to quickly change what the organisation does, and the way it does it, in response to changing external forces. The Covid pandemic is a classic example of this but there are many others. In most parts of the NHS, this change can be achieved by managerial actions but for primary care, the only tool (other than persuasion) is the contract which cannot be easily and quickly changed.

It should also be noted that there is now clear evidence that a significant proportion of GPs (but perhaps not a majority) would now support such a change in the organisation of primary medical care (BMJ 2016). Hence, the seems a good case for reform of primary health care services with services delivered by the NHS itself and not through private contractors. This would enable services to be designed and delivered in a more appropriate form than is currently the case.

Health care and social care integration

In 1948, healthcare became the responsibility of one organisation (the NHS) and social care continued to be the responsibility of different organisations (local authorities). This separation resulted in a number of problems since two services which were inextricably linked were now delivered by different organisations. Perhaps the most difficult issue of social care concerned older people where two particular features are paramount.

- The population of the UK (and many other countries) is ageing. In the UK, the proportion of the population deemed elderly (>65) rose from 16% in 2011 to 19% in 2021 (ONS 2021) and is projected to increase to 24% by 2043 (House of Commons 2021).
- The costs of health care per head of population are significantly higher for elderly and very elderly people compared to the average for the population as a whole.

The impact of this ageing population means there is a vital need for better coordination between NHS care and adult social care. At one level this would improve the quality of patient/client care, but the other key issue is what is termed delayed transfer of care (DTOC). This situation occurs when an elderly patient is medically fit to leave hospital but not fit enough to care for themselves unaided. In the absence of community based social care, the patient cannot be discharged from hospital and so remains in a bed which cannot then be utilised for another patient thereby resulting in longer waiting times.

Various solutions have been suggested. One involved creating a National Care Service paid for through national taxation as opposed to the current model paid from local sources. The Labour Party in opposition pledged a “programme of reform to create a National Care Service” in its manifesto in government but any action will await the report of an independent commission on the topic.

Under an NCS model, the funding for social care would be provided by central government but the implementing agencies would still be the same as now with a combination of local authorities, private sector and third sector providers. It is also suggested that social care (like heath care) would be free at the point of consumption, but this will be at a huge cost to the Exchequer. Moreover, this proposal deals with the funding issue but not the process of delivering social care which would still be delivered by separate agencies and, therefore, it is not clear how DTOC would be resolved.

Another approach was the introduction of what are termed Integrated care systems (ICS). In England, the 42 ICSs in England are local partnerships that bring health and care organisations together to develop shared plans and joined-up services. They are formed by NHS organisations and upper-tier local councils in that area and also include the third sector, social care providers and other partners with a role in improving local health and wellbeing. ICSs were established on 1 July 2022 and aim to do a number of things including Improving outcomes in population health and healthcare and tackling inequalities While such approaches seem laudable, it is not clear that they have had a major impact. In a published paper entitled Integrated Health and Social Care in England: Ten Years On, (Miller et al 2021) it was stated that, regarding the policy, "Despite progress within a few local areas, and reduction in delayed discharges from hospital the overall picture from national reviews was that expected improvements were not achieved". Achieving agreement at the top levels of organisations are not the same as delivering change on the ground.

A third approach might be the amalgamation of health and adult social care into one organisation (the NHS Trust). This is the situation in Northern Ireland. However, it isn't clear that the situation in Northern Ireland is much better than in the UK (Community Care 2021) and so it doesn't seem that structural changes being imposed on local bodies is the answer.

What is needed is not endless structural changes but the development of a greater understanding and improved collaborative working between health and social care staff, at the operational level. This would mean senior managers providing leadership and vision for what is required and must incorporate the three mutuals of mutual understanding, mutual trust and mutual gain for both health and social care staff. Unfortunately, these "soft" solutions seem to be beyond the understanding of London based politicians and civil servants. It is always the emphasis on changing structures.

Focus on preventative health care

Clearly it is better for incidents of ill-health to be prevented from occurring in the first place rather than having to treat the condition once it has occurred. Thus, we have the concepts of health promotion and preventative health care.

The WHO (2012) defined health promotion as being "the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions". The key features of this are seen as:

- **Building healthy public policy** - Health promotion is much more than health care. The aim is to put health on the agenda of policy makers in all sectors and at all levels.
- **Creating supportive environments** - societies are complex and interrelated. Changing patterns of life, work and leisure have a significant impact on health and these need to be considered and enhanced where possible.
- **Strengthening community action** - Health promotion should work through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health.
- **Developing personal skills** - Health promotion supports personal and social development through providing information, education for health and enhancing life skills.
- **Reorienting health services** - The aim here is to change the pattern of health services such that they place a greater emphasis on prevention as opposed to caring and curative activities.

Now all of these aspects are important but the one which is of most relevance to this paper is that of re-orienting health services towards prevention. Rightly, governments of different political persuasions have emphasised the importance of developing stronger and more effective approaches to preventative health care and there are examples of successful preventative programmes. However, there are other preventable diseases, which cause burdens for the patient and huge costs to the NHS, but where progress also seems limited. Something has to be done in this area, but it is not clear what the whole answer is regarding this matter. However, three suggestions are.

- The financing of preventative health care needs to be separated, and ring fenced from the rest of NHS funding. The problem is that when there is a financial crisis in the NHS, the budget for prevention is raided to shore up the finances of other services (BMJ 2014, Kings Fund 2021)

- Changing behaviour is key to success in preventative health care. However, it is suggested that such behaviour change should not just rely on “incentives” but should take a more authoritarian approach involving sanctions for failing to change behaviour. (NICE, 2007)
- Preventive health care programmes are not always successful. It is important to ensure that such programmes are designed on the basis of evidence of effectiveness and not the degree of political correctness.

Over-centralisation

This is the most difficult issue as it impacts on the other four issues already discussed.

A former UK foreign Secretary (Robin Cook) once said that the UK is one of the most centralised countries in the world (The Guardian 2002). Similarly, in 2010, the Economist (2010) suggested that the UK was "the second most centralised country in the developed world after New Zealand" which is, after all, a quite small country compared to the UK.

The reality is that, in the UK, the dominance of London applies, in physical, social, economic and especially political terms. Just consider the following:

- The monarchy and aristocracy
- Both Houses of Parliament
- The Senior Courts of Law
- The Bank of England
- The Civil Service
- Oxbridge and top London universities
- The city and the finance industry
- The BBC
- The media
- Big business
- Lobbyists
- Think Tanks
- NGOs
- The wealthy
- Celebrities

All of these institutions or social groupings have extensive power and influence on government decision making which impacts on what happens across the UK. It should not be surprising that the decisions made reflect the perceived wisdom in London with only limited input from outside the capital. The outcome of this is, of course, that the UK displays huge inequalities, in most fields (e.g. GDP/capita, health, education etc), between London/South East and the rest of the country. I have already mentioned the large inequalities in health resources and outcomes across the UK even though the NHS was set up as a national system with the aim of avoiding such inequalities.

This view of over-centralisation also applies to the management of health services, and many will argue that the management of the NHS in England is vastly over-centralised (BMJ 2023, Policy Exchange 2024). Writing about the failures of the UK Government in managing the Covid-19 pandemic the Economist (2020) stated that "In a federal system, like America's, the central government's failings can be mitigated by state and local authorities. In a centralised system, they cannot". This

was exactly the case in the UK where the hugely centralised system means that local authorities did not have the powers or the resources to compensate for the failings of central government.

I and many others (Prowle 2022) now argue that the UK's very centralised system of government is just not up to the task of dealing with the range and scale of issues being confronted, and it is suggested that whatever political party is in power, the government machine becomes dysfunctional (Cummins 2023, Latham & Prowle 2012).

Devolution of much of health service planning and implementation to regions of the UK would get health services planned and implemented by people more knowledgeable about the needs and wishes of the local populations rather than remote politicians and civil servants in London. Services could be more focussed on the needs of the regional population. It should also improve the interface between health, social care and other public services (Prowle 2022).

It is extremely unlikely that such a radical approach would ever be adopted not least because of London based vested interests and a centralised mindset, However, to have any hope of success in implementing the reforms need for the NHS, some attempt to get away from centralised Whitehall control must be made. While present government plans involve some devolution to regional mayors and local authorities in England, the extent to which such devolution takes place and whether that has any impact on central control of the NHS seems unlikely. Nevertheless, a stronger regional focus with regard to NHS policy and implementation, freed from micro-management by central government, remains almost a pre-requisite for dealing with the problems of the NHS.

A possible model here is the Sweden's health care system (Socialstyrelsen 2020) which is organised and managed on three levels: national, regional and local. At the national level, the Ministry of Health and Social Affairs establishes principles and guidelines for care and sets the political agenda for health and medical care. The ministry, along with other government bodies, supervises activities at the lower levels, allocates grants, and periodically evaluates services to ensure correspondence to national goals.

Regional responsibility for financing and providing health care is decentralized to the 21 county councils whose representatives are elected every four years on the same day as the national general election. The hospital board of a county council exercises authority over hospital structure and management and ensures efficient health care delivery. Health policy requires every county council to provide residents with good-quality health services and medical care and work toward promoting good health in the entire population. County councils have considerable leeway in

deciding how care should be planned and delivered. This does result in wide regional variations but then such inequalities exist in the centralised UK system.

At the local level, municipalities are responsible for maintaining the immediate environment of citizens, such as water supply and social welfare services. Also, post-discharge care for the disabled and elderly and long-term care for psychiatric patients is decentralized to the local municipalities.

Conclusions

This paper has described a series of large scale and radical changes needed to resolve the deep legacy problems of the NHS which have existed for decades but have worsened post-Covid. Any one of the five legacy themes discussed will require large scale changes in the way the NHS is organised, financed and care is delivered. This is a seemingly impossible task but, briefly, I summarise below possible suggestions under the following headings.

- What needs to be done?
- Means of resolution

What needs to be done?

As already noted, taken together, the changes proposed are of a different magnitude to anything faced in the past. Like most change programmes there will be strong resistance from many quarters which would need to be overcome. In addition, certain of these changes (e.g. hypothecated financing and decentralisation) will face huge resistance from civil servants and national politicians (Financial Times 2018, Tax journal 2018) even though it works perfectly well in other countries. It is difficult to see how resistance of this magnitude could be overcome. Furthermore, the sort of changes discussed in this paper will have enormous financial investment implications in themselves at a time when funding for public services is under extreme pressure. Clearly there is a huge agenda for change for the UK government, but can it be achieved?

Means of resolution

Given the above comments about dysfunctional government, it seems a very difficult, if not impossible task, to implement the range of health reforms discussed in this paper under the present system. Two possible approaches can be suggested as potential ways around this problem.

- **Elected Regional Devolution** – repeatedly noted has been the over-centralisation of health policy making and management with decision making being concentrated in the UK central government based in London. In some parts of the UK (Scotland, Wales and Northern Ireland) responsibility for policy making and management of many public services (including health) has been devolved to elected regional governments but in England (which is 84% of the UK population), no such regional devolution has yet taken place. The devolution of health policy and decision making to elected English regions might be a means for achieving the changes need to the health system to deal with the formidable problems (Prowle 2022)

- **Privatisation** – another approach might be to transfer some responsibility for the delivery of a comprehensive range of health services to the private health sector. The funding of health services would continue to be from public finance sources, but government would enter into contracts with private companies for a range of health services with clear service outcome measures. The private companies would also have responsibility for implementing the changes discussed in this paper.

However, at the time of writing, it is difficult to see either of these approaches being acceptable to any UK government and also there may be resistance from the general public. Consequently, it is difficult to see a clear path ahead for the UK NHS, but the ongoing challenges might lead to greater acceptability in the future.

My personal view that we live in an age where to be optimistic is almost compulsory and to be pessimistic is somehow seen as "letting the side" down. I always emphasise that the issue should not be one of optimism or pessimism but one of realism. False optimism or pessimism can both be dangerous. Many authors have written about "the curse of optimism" and one commentator (Anand 2018) sums up this problem:

"Unfortunately, our visions do not always translate into reality. But, instead of cutting our losses most optimists choose to double down. They figure they can still beat the system but just ran out of time or resources the first time around. Such resilience may be desirable or even heroic, but it is also the curse of optimism. It bleeds into our ego and reduces our ability to make strong rational decisions. At some point, we cannot differentiate between the failure of our efforts and our bruised self-worth".

Hence, I see it as optimistic, in the extreme, that the UK central government machine can be reformed. We hear a lot of talk from virtually every political party about re-engineering, or rewiring, central government but that misses the point that the existing central government machine is unreformable. What we can expect is repeated changes of government incorporating new political parties as well as the traditional ones with the departing government having been seen to have failed.

References

Appleby, J. & Harrison, A, (2006). Spending on Healthcare: How much is enough. Kings Fund 2006

BBC. (2023). NHS waiting lists hit record high in England. https://www.bbc.co.uk/news/health-66188529

BMJ (2014). Raiding the public health budget. 27 March 2014. https://www.bmj.com/content/348/bmj.g2274

BMJ (2016). Should all GPs become NHS employees? https://www.bmj.com/content/355/bmj.i5064

BMJ. (2023). NHS is failing patients through lack of coordinated and holistic care, Lords warn.

BMJ (2025). Government's 10-year plan for the NHS in England,4 July 2025

Cohen, S (2020). The NHS: Britain's National Health Service 1948-2020. Shire Publications

Community Care (2021). How the UK's four social care systems measure up against each other. https://www.communitycare.co.uk/2021/05/11/uks-four-social-care-systems-measure/

Computer Weekly (2010). Six reasons why the NHS National Programme for IT failed. 13 Sept 2010

Cookson, R, Laudicella, M, Li Donni, P & Dusheiko, M (2012) Effects of the Blair/Brown NHS reforms on socioeconomic equity in health care, Journal of Health Service Research Policy. 17 Suppl 1:55-63

Cummins, D. (2023). Witness statement of Dominic Cummings dated 12/10/2023 to the UK Covid Inquiry

DHSC 2024). Independent investigation of the NHS in England. Department of Health and Social Care. Sept 2024

Doetinchem, Ole (2010). "Hypothecation of tax revenue for health". World Health Report (Background Paper, 51).

Financial Times (2018) Should there be a ringfenced tax to fund the NHS? 10January 2018. https://www.ft.com/content/9feb8c0c-f467-11e7-8715-e94187b3017e

Financial Times. (2023). Why is the NHS in its worst ever crisis. https://www.ft.com/content/b593116d-f948-4757-b2fa-c74adadc8b42

Griffiths, J. (2024). Improving the interface between primary and secondary care. NHS Confederation. https://www.bbc.co.uk/news/health-66188529

Health Foundation (2015). How funding for the NHS in the UK has changed over a rolling ten-year period. October 2015

Health Foundation (2024)/ How much funding does the NHS need over the next decade? 20 June 2024

Health Foundation. (2024). Health at the heart of government. https://www.health.org.uk/a-bill-of-health

House of Commons Library (2021). Housing an ageing population: a reading list'

Hudson, R. (2019), Why policy failure is so common in the UK, https://blogs.lse.ac.uk/businessreview/2019/01/26/why-policy-failure-is-so-common-in-the-uk/

IEA. (2025). The Uncomfortable Truth About Why British Government Is Failing February 2025

Keable-Elliott, India (2014). "Hypothecated taxation and the NHS". CentreForum

Kings Fund (2018). Hypothecated funding for health and social care: How might it work? May 2018

Kings Fund (2021). The Comprehensive Spending Review – what more for health and care spending? 11 October 2021. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/comprehensive-spending-review-health-and-care-spending

Kings Fund (2022). The rise and decline of the NHS in England. 2000-2020. https://assets.kingsfund.org.uk/f/256914/x/0ab966500b/rise_decline_nhs_england_2000-20_2023.pdf

Kings Fund (2024). NHS workforce in a nutshell. May 2024. https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell

Latham. R. & Prowle, M.J. (2012). Public Services and Financial Austerity. Palgrave MacMillan

Miller, R, Glasby, J. & Dickinson, H. (2021). Integrated Health and Social Care in England: Ten Years On. Int J Integr Care. 2021 Oct 29;21(4):6. doi: 10.5334/ijic.5666

NHE (2024). What is stopping NHS digital transformation? https://www.nationalhealthexecutive.com/articles/what-stopping-nhs-digital-transformation

NHS Confederation (2025). Ten-year health plan: What you need to know. Ten-Year Health Plan: what you need to know | NHS Confederation

NHS Foundation (2020). Over 700,000 patients served by GPs at high risk of COVID-19 could be left without access to face-to-face GP appointments. 6 August 2020

NHS Networks. (2023). How should GPs be employed?

NHS Providers (2024). Reducing 'unwarranted' variation and the GIRFT programme.

NICE (2007). Behaviour change: general approaches

Nuffield Trust. Reform of the National Health Service Chronology

ONS (2021) Profile of the older population living in England and Wales in 2021 and changes since 2011.

ONS (2023). Population estimates for the UK, England, Wales, Scotland and Northern Ireland:

ONS (2024). Accident and Emergency wait times across the UK: 2024. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/accidentandemergencywaittimesacrosstheuk/2024-02-28

Policy Exchange. (2024). Just About Managing: The Role of Effective Management and Leadership in Improving NHS Performance and Productivity. September 2024

Prowle, M.J. (Ed). (2022). Reforming UK public policy through elected regional government, Routledge 2022

Public Health England (2018). Introduction to evaluation in health and wellbeing

Seely, Antony (September 2011). "Hypothecated taxation". House of Commons Library Standard Note SN01480.

Richards, D., Smith, MJ, & Marsh D (2024) Crisis what crisis?' Understanding the recurring problems of the British state. The British Journal of Politics and International Relations. Volume 27, Issue 2

Smith, J (2025), NHS ten-year plan for England: what's in it and what's needed to make it work.

Smith, M. (2025) Overload, decline and government failure: 60 years of UK crisis and crisis literature—a review. Br Polit 20, 435–452

Socialstyrelsen (2020). About the Swedish healthcare system. https://www.socialstyrelsen.se/en/about-us/healthcare-for-visitors-to-sweden/about-the-swedish-healthcare-system/

Tax Journal (2018). Hypothecation, health taxation and hysterisis' 25 April 2018

Taylor, M. (2023). Innovation can help streamline NHS, Digital Health 2023

The Economist (2010), Time to rebalance, April 2010

The Economist. (2020). Britain has the wrong government for the covid crisis. June 2020

The Guardian (2002), Britain is most centralised state in Europe, 3 November 2002

Thomas, Symonds, N. (2014). Nye: The Political Life of Aneurin Bevan. IB Tauris 2024.

Tweddell, L. (2008). The Birth of the NHS – July 5th, 1948. Nursing Times January 2008

Which (2023). Why is it so hard to get a GP appointment. https://www.which.co.uk/news/article/why-is-it-so-hard-to-get-a-gp-appointment-agsTT2p0SeE3

WHO (2012). Ottawa charter for health promotion. 16 June 2012

Zhang, J (2022), Failing IT infrastructure is undermining safe healthcare in the NHS. https://www.bmj.com/content/379/bmj-2022-073166

About the author

Since 2017, Malcolm Prowle has been professor of performance management in the University of Gloucestershire Business School. He has extensive experience of strategy, financial management and performance management in both private and the public sectors. This was gained by wide ranging experience (in the UK and overseas) of: -

- Senior management – he has held senior financial management posts (up to FD level) in several organisations.
- Management Consultancy – for twenty years, he held senior positions with two major international consulting firms (KPMG and PWC) where he worked on assignments for a wide range of public and private sector clients in both the UK and overseas.
- Academic teaching and research - has held university posts at the Universities of Warwick, Wolverhampton, Gloucestershire and Nottingham and a number of visiting academic posts at other universities including, Bristol, Aston, Open University and Cardiff

As a management consultant, he led or participated in several hundred large, complex and often politically sensitive projects in both the public and private sectors. He has extensive technical experience of strategy, financial management and performance management but also the process of managing the change process in client organisations. As a consultant, he has substantial international experience and has worked on major consultancy projects in Brazil, Turkey, India, Sweden and Cyprus.

He has worked at the highest levels of government and has advised Ministers, Ambassadors, senior civil servants and service professionals on a variety of public policy and policy implementation issues. He had several long secondments to central government departments and has been an adviser to two House of Commons Select Committees, He has spoken and presented papers at a wide range of events and conferences including that of: the Prime Ministers Policy Unit, the Government Accounting Service, the CBI, the World Health Organisation as well as academic and professional conferences

He is an active researcher and has led and/or participated in many funded research projects, which have led to published research reports and papers. This includes eleven full-length books, three book chapters, numerous research reports and papers in both academic peer refereed and professional journals.