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Editorial

The National Health Service: Where Are We and How Did We Get Here?

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1. Introduction

The establishment of the National Health Service (NHS) came about in 1948 as the incoming Labour government planned to eliminate 5 giants including disease. Since then both the NHS and society at large have changed dramatically often at different paces as have societal expectations. Perhaps the time is right to reassess the function and the focus of the NHS. Like all clinical decisions, it is important to identify what is wrong and then look at how it can be fixed. So where are we as far as the NHS is concerned and how did we get here?

2. Sources of Pressure on the NHS

Various factors (in no particular order) which have got the NHS to this point where it is struggling more than usual, are as follows: various government policies often based on political ideologies, broader specialisation, various medical scandals, changing public expectations, equality of doctor-patient interaction, development of new technologies, increasing anti-scientific bias in society as evinced by anti-vaccination waves among politicians and public, increasing consumerism and commodification of health (i.e., health being seen as a commodity and being bought and sold), financial cuts and economic downturn.

It was right to introduce management in the NHS and good managers are significant contributors to the smooth running of the services, but in many settings, increased managerialism has unfortunately led to increased bureaucracy. Endless form filling has become the norm. This may also reflect defensive practice and fear of litigation. Funding for the NHS has not kept pace with increasing demand, more expensive investigations and treatments and inflationary pressures. Increased litigation and compensation have also contributed to financial pressures. Socio-demographic changes have led to people living longer, often with multiple physical and psychiatric complex comorbidities which require multiple interventions. In addition, sometimes there is an undercurrent against those working in the public sector thinking being that they could not make it in private sector rather than appreciating the public spirited vocations. A kind of classist attitude appears to be at play here. From privatisation of catering and cleaning to Private Public Initiatives (PPI) to the use of private laboratories, and private beds financial pressures have continued to mount. Measurement of various functions in the NHS has expanded, but often without clear evidence of proportional professional benefits particularly when patients get reduced to a set of symptoms rather than individuals with specific healthcare and social needs. To date, no politician has been honest and brave enough to stand up and say what needs to be paid for and how it should be paid. Each political party promises suitable funding especially when they are in opposition but often fail to deliver when in government.

3. Workforce Challenges

The NHS has a large workforce and yet workforce planning appears to be missing in action. With the best will in the world, new public and private medical schools were set up but no due thought appears to have been given to creating training posts after graduation. As a result, UK medical graduates leave for other pastures and the UK looks at the Global South and former colonies to recruit trained staff, thus further depleting countries which can ill afford to lose these resources. Newer professions (*e.g.*, physician assistants or associates, anaesthesia assistants, nursing specialists etc) are beginning to emerge but looking from the outside in, it seems that again there appears to be no joined up thinking about their roles and responsibilities, actual functions, numbers, training or supervision and regulation. The morale in the NHS staff is low and with consistent attacks on migrants the brunt of racist abuse continues to be borne by minority staff who very often are in the front line. Due to a lack of proper planning, locum agencies are often helping fill the posts by charging huge fees to place people and in addition such locum staff are often being paid additional sums thus contributing to increasing financial pressures. Many locum agencies have been set up by ex-NHS staff who have the inside track to subsequent appointments [1] (pp 27). This leads to regular staff feeling undervalued, unsupported, abused and overwhelmed leading to burnout. High rates of staff turnover in many settings with persistent vacancies have in turn created high rates of burnout and poor morale, ultimately making working conditions even more stressful [2].

In addition, generational differences in attitudes to work-life balance have been ignored. Younger generations are more aware of maintaining a work-life balance hence their expectations are very different [3]. Furthermore, increasingly more women are training as medical students and their priorities are likely to be different. Increasingly health is being seen and sold as a commodity which means that it can be bought and sold thereby creating a public expectation that perhaps people do not need to take any personal responsibility for it. This may well have major implications for public health.

4. Primary Care

Primary care physicians (general practitioners) provide an invaluable service but are often ignored by the policymakers with focus remaining on secondary and tertiary care measuring waiting lists and times rather than looking at the antecedents of the long waiting lists. The GPs hold valuable information on their patients. They coordinate referrals and care; very often because of the detailed knowledge of the person and their family and circumstances, they are perfect partners to the specialist services though regrettably seen as gatekeepers only and hence perceived as having a lower status. Primary care settings are well placed and do offer public health interventions and screenings as primary prevention to avoid development of illnesses-offering vaccinations, social prescribing, prostate and other screenings but often do not get the support they need. Fundholding created problems of its own by creating two-tier service [4] the sequelae of that continue to reverberate in various forms.

5. Funding

Increasing and competing demands and inadequate funding have led to piecemeal and patchwork repairs. Beds are often the most expensive part of the service so reduction in the number of beds was a rather ill-thought-out step which then led to 'buying beds' from private sector which in many specialities has led to increased length of stay. Anecdotally it appears that despite their theoretical financial freedom, Foundation Trusts which exist in England alone, are still controlled very heavily from the centre and thus contributions towards existing and newer infrastructures remain very patchy.

The governance infrastructures including regulatory bodies appear to create further layers of managerialism, bureaucracy and defensive practice. Hence the question needs addressing: are these bodies fit for purpose and who regulates the regulators and what can be done about these?

As is, it would also appear that the NHS is two tiered, encompassing differences between London teaching hospitals and other parts of the country. Similarly, workforce challenges are uneven and place-based where some regions and some specialties remain persistently under-recruited.

Uniform centrally controlled national job offers among residents and other medical staff fail to address local realities and population needs.

6. Training

Training was previously supported not just through funded education but through practical scaffolding: subsidised accommodation, meals, and security of job during early careers. Today's doctors routinely carry large student debt, alongside examination fees, relocation costs, and portfolio requirements. Medicine has shifted from a publicly supported vocation to a high-risk personal investment. From assured employment to competitive scarcity has meant that often at the beginning of one's career, the morale is quite low and may well stay so.

Doctors once had expected almost guaranteed work on completion of training, even if not in their preferred specialty or location. But with intense competition, progression bottlenecks, and uncertainty about end-state roles paradoxically alongside workforce shortages has inevitably contributed further to low morale and burnout leading to emigration.

Ironically, junior doctors have been relabelled residents when very often there is no place for them to reside in. The curriculum for medical education often still dates to the last century and very often new topics are added without anything much being taken away thereby adding to the pressures and consequent burnout. In some settings, the NHS has often failed to create multidisciplinary teaching and learning strategies so when individuals are thrown into teams, their expectations of each other create problems and tensions and consequently they may find it difficult to adjust.

7. Social Care

Over the past few decades, especially in England, despite governments recognising that social and health care need to come closer together, there appears to have been an aversion to changing the relationship even when policymakers know that improving social care will relieve the pressure on healthcare. In England, social care is left to the local authorities and councils whose budgets have been decimated over the last decade or so. Similarly, public health has been decimated as it was placed in the council budgets. A lack of coherent social care as well as public health strategy has produced increased pressure on beds and hospitals. The role of political, commercial and geographical determinants in contributing to ill-health of populations needs to be always considered. Decisions and policies under the guise of reforms, are often ideological rather than evidence based. Pressures on the NHS were obvious during the COVID-19 pandemic when the routine work slowed down which then added to the pressures on the NHS once the country came out of the pandemic.

NHS remains a major contributor to a sense of purpose, altruism and equity. The social contract in the health context is a tripartite one and seems to have lost its purpose. The public expectations as well as social and cultural expectations have shifted from trust to surveillance.

Professional trust has been replaced by repeated assessment, revalidation, mandatory training whether it is useful or not, and governance activity.

8. Conclusion

NHS provides a worthwhile health care irrespective of an individual's ability to pay. From cradle to the grave people with acute and chronic diseases are looked after. The challenges in its functioning result from political ideologies and workforce issues related to financial pressures. Health is being seen increasingly as a commodity. Increased bureaucracy, lack of workforce planning and difficulties in training pathways contribute to pressures. Reasons for increased demand and consequent financial pressures also include changing demographics and changing public expectations of the services. Complex co-morbidities in the older adult population and lack of integration of social and healthcare in England lead to additional problems. Financial pressures are also related to increasing demand and expensive interventions which contribute to dissatisfaction with the service. In a subsequent editorial we will offer some suggested solutions.

Key Points

• NHS faces unprecedented pressures due to changes and expectations in society and these are further complicated by financial matters and political ideologies.

• In addition, changing generational expectations put a tremendous amount of pressure on the services.

• Workforce related pressures add further stress on already overstretched services.

• Lack of integration of social services and healthcare adds a further dimension of stress on the system.

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Author Contributions

DB created the first draft and RW revised it critically for important intellectual content. Both authors made substantial contributions to the conception and design of the paper and writing. Both authors gave final approval of the version to be published. Both authors have participated sufficiently in the work to take public responsibility for appropriate portions of the content and agreed to be accountable for all aspects of the work in ensuring that questions related to its accuracy or integrity.

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Conflicts of Interest

The authors declare no conflicts of interest.

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