British Journal of Hospital Medicine

Br. J. Hosp. Med. (Lond) **2026**; 87(10): 55494
https://doi.org/10.31083/BJHM55494

Editorial

The Future of the NHS: What Is Needed for Change and How Do We Get There?

Dinesh Bhugra[1,*], Rajiv Wijesuriya[2]

[1]IoPPN, King's College London, SE5 8AF London, UK
[2]Cropwell Bishop Surgery, NG12 3BU Nottingham, UK
*Correspondence: Dinesh.Bhugra@kcl.ac.uk (Dinesh Bhugra)
Academic Editor: Livio Garattini
Submitted: 1 July 2026 Revised: 6 August 2026 Accepted: 27 August 2026 Published: 19 October 2026

Healthcare delivery is complex. The development of symptoms, their recognition as abnormal experiences and subsequent help-seeking are affected by several factors. On a daily basis there are stories in the media about new developments and new therapeutic interventions. At the same time, there are negative reports highlighting ongoing enquiries, waiting lists and chaos in the NHS. There is often a dissonance in what patients and carers expect and what is provided in clinical care.

As discussed previously, there are many challenges faced by the NHS [1]. These challenges reflect changing societal expectations, demographic shifts, and evolving societal needs. We believe that a key solution is to understand and renew medicine's social contract. A harmonious relationship between healthcare providers and potential users of such services is important [2], and medicine's social contract can provide a way forward.

Medicine's social contract:

Health cannot and should not be seen in isolation from factors such as poverty, education, housing, overcrowding, lack of green spaces, poor access to transport, secure employment, etc., which are all affected by geopolitical factors.

Traditionally, social contract emerged as an implicit unsigned contract between the monarch and their subjects where through giving up certain liberties and paying tax contributions the subjects expected the ruler to provide safety and security. This concept has been applied to medicine and is between health professionals and patients but also between funders and healthcare professionals as well as the population including patients. This social contract according to Cruess and Cruess [3] has similarities with moral contract, compact or covenant and as a metaphor, emphasises medical professionalism [4]. In view of the changes in society and societal expectations and advances in healthcare, there is an urgent need to explicitly restate and review medicine's social contract.

Medicine's social contract is between the funders (the government in this case), patients and their carers as well as the general population and those who provide healthcare. As demographics change, newer conditions and treatments emerge, demands change. Thus, dialogue has to be an ongoing one [3]. Although there are three partners, they often do not have equal say and responsibility. The government provides funding and in return expects competencies, skills, accountability and transparency from the professionals who expect that funding be adequate and sufficient, they be allowed self regulation and clinical autonomy and a role in helping develop policies. Patients and public expect the government and the healthcare professionals to provide accessible, appropriate, equitable and good quality services, the policymakers to be held accountable and for themselves to be an equitable partner in any discussions. Patients and their carers and families expect health care providers to be professional, skilled, altruistic, moral, transparent, accountable and source of public good. The social contract provides a framework for ongoing discussions as political and economic climates change. As Cruess and Cruess [3] suggest social contract has to be evolutionary through (regular) open discussion. Medical professionalism and professional values are related to the social contract [4] by ensuring that physicians belong to what is described as a community of practice. The tension between the partners must be managed [5].

Following our previous observations [1] we suggest following recommendations which are in no particular order.

Suggestion 1: Recruitment and retention:

Recruitment and retention of NHS staff needs to be one of the top priorities. There are notable gaps in geographical areas and across specialities [6,7]. Workforce planning needs to be long-term as a core component of the social contract. The culture and ethos of public sector must be celebrated. Training must be supported through practical scaffolding: accommodation, meals, and security during early careers. For many, medicine has shifted from a publicly supported vocation to a high-risk personal financial investment and thus from a sense of vocation and purpose to asset management. Employers have a moral and ethical duty to look after their staff and thus simple measures like spaces to relax, providing affordable nutritious food, access to affordable childcare (including hospital crèches), flexible return-to-work arrangements can help staff feel appreciated. Lack of flexibility is a key problem [8]. A key

Copyright: © 2026 The Author(s). Published by IMR Press.
This is an open access article under the CC BY 4.0 license.

Publisher's Note: IMR Press stays neutral with regard to jurisdictional claims in published maps and institutional affiliations.

debate must be had to look at recruitment from elsewhere and emigration of British-trained staff.

Suggestion 2: Infrastructure:

Physical infrastructure for the NHS must be regularly upgraded. There must be an adequate number of beds with a variety of options such as non-residential facilities, short-stay wards and community hubs and beds through to long-stay wards, where appropriate. This requires clear partnerships with social care, councils and local communities. Public health services must be brought back into the NHS as an integral part of health care and public education. Using 5- or 10-year NHS plans as a basic starting point, with regular consultation with staff and public is a good start but there must be room for innovation.

Suggestion 3: Newer professions:

In the past couple of decades there has been an increased development in the numbers of newer medical professionals. These include physician assistants, physician associates, nurse practitioners, nurse specialists, who can be incredibly important partners in healthcare delivery but it is urgent to identify their roles, responsibilities, regulation, career development, etc. These are welcome developments but need careful thought rather than being seen as simply cheaper options. It has been suggested that the role of these new professions can be innovation, enhancement, delegation and substitution [9] not only this requires extremely careful and critical thinking within the healthcare systems but also discussions with partners.

Suggestion 4: Public Health:

People, populations and patients must be encouraged, educated and trained to take responsibility for their own health through public education. In this evolving era of AI and ever-increasing reliance on the internet to assess one's health and health needs it is essential that patients, their families and carers and the general population get correct and culturally relevant information in an accessible format.

Suggestion 5: Health impact assessment of policies:

As a recent study [10] noted that the Home Office policy following the Windrush scandal increased rates of psychiatric disorders in black minority populations, it is imperative that the impact of all policies on health should be assessed to avoid similar unintended consequences. Political, commercial and geographical determinants of health must be considered and decisions made accordingly. Learning from examples of good practice elsewhere in the world can be incredibly helpful.

Suggestion 6: Regulation:

Regulatory bodies have an important role to play provided they can get their own house in order. Regulation should enable sustained and sustainable improvement, not crowd it and must be facilitatory rather than punitive. Current punitive approaches often generate a climate of fear, anger, frustration and disappointment. Often the people who have the most workload tend to have the least amount of power and are likely to be blamed when things go wrong. Individual practitioners under investigation should be supported and where needed coaching and mentoring must be made available.

Suggestion 7: Service development:

Specialisation is essential and helpful in providing long-term high-quality secondary care. However, it has been seen in practice that many specialist services tend to put up the moat bridges to exclude patients due to pressures and limited resources. Perhaps a new model of care would be that specialists also work as generalists part of the week. Generalists and specialists must work together and ensure professional development. Better coordinated use of telehealth and AI can help focus on providing best quality healthcare. Joint learning and training across disciplines and across specialties can help provide better care.

Suggestion 8: Legal impact:

Medical scandals add to the NHS bill and there needs to be a clear debate about the implications of legal interventions, compensation, and other related costs. Medical Protection Society [11] noted that clinical negligence claims cost the NHS US $4.3 Billion last year. An open honest debate between public and politicians is indicated as has been demonstrated in other countries [12].

This is not a call to mourn or even return to a "golden age" of the NHS as there probably never was. Societal expectations and circumstances were different. Many so-called reforms were well-intentioned and necessary but equally many were influenced simply by simple political ideologies and dogma. The opportunity now is to explicitly restate the social contract—aligning expectations with reality, sharing responsibility, and designing systems that allow doctors to practise well, sustainably, and with pride. The time is ripe to look at the NHS afresh-what it stands for and how best to help it in a sustainable manner. In order for the NHS to survive and flourish, all stakeholders need to bring new ideas about work of the NHS and their expectations from the NHS to the table and agree on these parameters. With increasing use of AI and telehealth, it should be easier to connect health with education, employment, housing, transport, social care and justice among others. It is essential that all stakeholders are actively involved in any change as true partners. Healthcare professionals must feel that they have a stake and agency rather than things being done to them. Learning from other countries sharing examples of good practice can help foster new ideas and energy. NHS must have a long-term plan with cross-party support rather than being a political football.

Key Points

• Health needs to be seen not in a silo but linked with housing, employment, poverty, education, transport, and other social determinants, all of which are affected by political and commercial determinants.

• For the NHS to thrive and survive, it needs long term planning in infrastructure, training and workforce planning.

• Additional factors such as the role of regulatory bodies, clinical negligence, compensation costs, and health impact assessment of all policies need to be taken into account for the survival of the NHS in the long-term.

Availability of Data and Materials

Not applicable.

Author Contributions

Both authors discussed the concepts and review. Then DB drafted the paper. DB and RW have been involved in revising it critically for important intellectual content. 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.

Ethics Approval and Consent to Participate

Not applicable.

Acknowledgment

We are grateful to Alexander Smith for his overview and editing of an earlier version of this paper.

Funding

This research received no external funding.

Conflicts of Interest

Rajiv Wijesuriya is an employee of Cropwell Bishop Surgery. This private organization was not involved in the conception and design of this study, data collection, analysis, interpretation, paper writing, or submission decisions. The authors declare no conflicts of interest.

References

[1] Bhugra D, Wijesuriya R. The National Health Service: Where Are We and How Did We Get Here? British Journal of Hospital Medicine. 2026; 87: 54477. https://doi.org/10.31083/BJHM54477

[2] Samant M, Santosh S, Dutta S, Joshi M, Calnan M, Kane S. Understanding disruption in the social contract between the medical profession and society in India: a tale of mismatched expectations? Health Policy and Planning. 2026; 41: 71–80. https://doi.org/10.1093/heapol/czaf077

[3] Cruess S, Cruess RL. Medicine's social contract with society: its nature, evolution and present state. In Bhugra D, Malik A, Ikkos G (eds.) Psychiatry's contract with society: concepts, controversies and consequences (pp. 123–141). OUP: Oxford. 2011.

[4] Caleb AM. The Social Contract of Medicine. In Crawford P, Kadetz P (eds.) Palgrave Encyclopedia of the Health Humanities. Palgrave Macmillan: Cham. 2022. https://doi.org/10.1007/978-3-030-26825-1_50-2

[5] Bhugra D. Medicine's social contract. Journal of the Royal Society of Medicine. 2024; 117: 102–103. https://doi.org/10.1177/01410768241230772

[6] Alkan E, Cushen-Brewster N, Anyanwu P. Investigating healthcare workforce recruitment and retention: a mixed-methods study protocol. BMJ Open. 2024; 14: e074100. https://doi.org/10.1136/bmjopen-2023-074100

[7] Buckingham N. NHS workforce in a nutshell. 2025. Available at: https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell (Accessed: 5 August 2026).

[8] Kirby R. Dealing with the NHS staff recruitment and retention crisis: how are we doing? Trends Urology & Men Health. 2023; 14: 28–30. https://doi.org/10.1002/tre.892

[9] Palmer W, Crellin N, Lobont C. In the balance: Lessons for changing the mix of professions in NHS services. 2025. Available at: https://www.nuffieldtrust.org.uk/sites/default/files/2025-01/Nuffield%20Trust%20-%20In%20the%20balance_WEB.pdf (Accessed: 5 August 2026).

[10] Janes K, Vernon P, Estefan D, Sheibani F, Caesar G, Burgess RA. The ties that bind: Understanding the mental health consequences of the Windrush Scandal and hostile immigration policies on survivors in the UK. SSM - Mental Health. 2024; 6: 10035. https://doi.org/10.1016/j.ssmmh.2024.100352

[11] Davies S. Costly, inequitable clinical negligence system must be tackled urgently. 2026. Available at: https://www.medicalprotection.org/uk/advice-centre-articles/costly--inequitable-clinical-negligence-system-must-be-tackled-urgently (Accessed: 5 August 2026).

[12] Kampfner J. Braver New World. Atlantic Books: London. 2026.