More doctors choose to retire early

Increasing numbers of doctors are opting to retire early rather than wait to claim their pension at retirement age, figures show.

The number of GPs and hospital doctors in England and Wales opting for voluntary early retirement has risen by an average of 9.3% year on year, rising from 376 in 2008 to 1424 in 2023, data from NHS Business Services show. Over the same period those retiring on reaching retirement age has fallen, from 2030 in 2008 to 1721 in 2023. The number of hospital doctors retiring early rose from 178 in 2008 to 557 in 2023, while the number of GPs doing so rose from 198 to 867.

Overall, the total number of doctors retiring has risen by 35% over the past 15 years, from 2431 in 2008 to 3277 in 2023. Over the same period the number of doctors employed by the NHS in England and Wales has risen by 33% from 141 000 in 2008 to 187 000 in 2023.

The figures were provided to The BMJ in response to a freedom of information request. They relate to doctors who claimed their NHS pension in a specific pension year, some of whom may have returned to work in the NHS in other roles after claiming their pensions.

Vishal Sharma, chair of the BMA consultants and pensions committees, said the data supported what the BMA had been saying for many years: “that a large and increasing number of senior doctors are retiring, and most worryingly, doing so early.”

He added, “These doctors are at the pinnacle of their careers. They not only provide highly specialised care but are responsible for training and supervising the consultants and GPs of the future.”

Sharma said the trend coincided with pension taxation rules that penalised doctors for extra hours or staying in work. “The changes in this year’s budget were broadly welcome, but they will have come too late for some,” he said. “It will be some time before we can properly evaluate the impact on the lifetime allowance, and there will be doctors hit by the tapered annual allowance, which has still not been meaningfully reformed.”

He added, “It’s imperative the government fixes pay and urgently publishes a workforce plan. It has no hope of fulfilling its pledge to cut waiting lists if it loses its most senior staff.”

Sarah Tennant, chair of the pension committee of the hospital doctors’ union HCSA, said the figures showed the “disastrous impact of government inaction.” She added, “Consultants and specialists who are tired of playing Russian roulette with tax have chosen to leave rather than risk unexpected charges.”

Tom Moberly, The BMJ
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Flu

UK deaths hit five year high last winter

Nearly 15 000 excess deaths associated with influenza were reported in the 2022-23 flu season—the highest figure since 2017-18, which had 22 500 excess deaths. In a report on the first season in which flu has been widespread since the pandemic, the UK Health Security Agency said that hospital admissions across all ages were higher than average. Conall Watson, the agency’s lead influenza epidemiologist, said, “Flu returned at scale last winter in its first season in which flu has been widespread since the pandemic, with hospital admissions across all ages being higher than average.”

Smoking

Government is set to miss pregnancy target

Campaigners have warned the government will not reach a target it set in 2017, to reduce the percentage of people who smoke while pregnant to 6% by 2022, for another decade. Data show 8.8% of pregnant people smoked in 2022-23, and modelling by the Smoking in Pregnancy Challenge Group shows the 6% target will not be reached until 2032 if rates continue to decline at the rate they have since 2015.

Abortion

First half of 2022 saw steep rise in demand

Just over 120 000 abortions were performed in England and Wales in January to June 2022, up 17% from the same period in 2021. Most abortions (67%) took place by seven weeks’ gestation, and 98% occurred by 17 weeks. Nearly 350 abortions were in women who lived outside England and Wales: 28% of those came from Northern Ireland and 25% from the Republic of Ireland. Clare Murphy, chief executive of the British Pregnancy Advisory Service, said the figures suggested financial pressures had forced some abortions.

Committee recommends vaccine for older adults

The Joint Committee on Vaccination and Immunisation has advised that the respiratory syncytial virus (RSV) vaccine should be given to infants and to older adults. The NHS currently offers the vaccine to a small group of infants at high risk of severe complications, such as those born prematurely. Andrew Pollard (left), the committee chair, said RSV illness placed a “significant burden” on the UK population and the NHS in winter. The government is expected to announce its final plan on the vaccine later this summer.

Research

Raft of journals miss open access targets

Two thirds (68%) of journals in the Transformative Journals (TJ) programme failed to meet their open access growth targets, meaning they will be removed from the Plan S funding scheme. Just over 1 500 titles will lose their TJ status, including many titles published by Springer Nature, the American Chemical Society, and Elsevier. The publishers that did well included BMJ (94% of 32 journals met targets) and Cambridge University Press (62% of 240 journals).

Public health

Charity calls for new CVD focus to reduce deaths

Nearly 100 000 more people with cardiovascular disease (CVD) than expected have died in England since the start of the pandemic in February 2020, an analysis from the British Heart Foundation found. It said that in the pandemic’s first year covid infections drove high numbers of excess deaths involving CVD (above), and while deaths from covid have fallen, those from CVD remain above expected levels. The charity called for renewed focus on preventing the causes of CVD and to boost treatment research.

Junior doctors in England will go on strike for five days from 13 to 18 July, in what is believed to be the longest walkout in NHS history, the BMA has announced. BMA Junior Doctors Committee co-chairs Robert Laurenson and Vivek Trivedi (left) said in the week since the last round of strikes neither the prime minister Rishi Sunak nor the health secretary Steve Barclay had contacted the BMA to reopen negotiations. They said, “What better indication of how committed they are to ending this dispute could we have?”

Talks collapsed in May, with the union saying the government was refusing to budge from its final pay rise offer of 5%. The BMA has said it will take at least three days of strike action every month over the summer, until its current mandate runs out at the end of August. It is currently re-balloting its members to extend the mandate.

Meanwhile, on Tuesday, the BMA announced consultants in England will also be striking next month after over 20 000 voted for action over pay. The union balloted members between 15 May and 27 June and on a turnout of 71% (24 106) 86% voted for strike action. The BMA said that, unless the government comes forward with a credible offer that it can put to its members, consultants in England will strike on 20 and 21 July.

Elisabeth Mahase, The BMJ Cite this as: BMJ 2023;382:p1448
**MEDICINE**

**AI**

**Government announces £21m fund for NHS**

NHS trusts will be able to apply for funding to roll out artificial intelligence (AI) imaging and decision support tools to help quicker diagnosis of conditions such as cancers, strokes, and heart disease, as part of a new AI diagnostic fund scheme. The health secretary has also committed to rolling out AI stroke diagnosis technology to all stroke networks by the end of 2023, up from 86% today. With more than 600 000 chest x rays performed every month in England, AI diagnostic tools could enable clinicians to diagnose cancer earlier, improving patient outcomes, the government said.

**CQC**

**Visiting could become a legal part of care**

The UK government has proposed legislation to make visiting a legal requirement for hospitals, care homes, mental health units, and other health and care settings, to allow people in these settings to have visitors in all circumstances. The legislation would give the Care Quality Commission a clearer basis for identifying where hospitals and care homes were not meeting the required visiting standards and would give it the power to issue requirement or warning notices, impose conditions, or suspend or cancel a registration.

**Malaria**

**Belize is certified malaria free by WHO**

The World Health Organization has certified Belize as malaria free, after three decades of work to reduce the burden of the disease from a peak of 10 000 cases in 1994 to zero indigenous cases in 2019. The country’s success is based on strong surveillance, access to diagnosis, and effective vector control methods including insecticide treated mosquito nets and indoor spraying of insecticides. Trained community health workers have also played a vital role in timely diagnosis and treatment, and during the covid-19 pandemic Belize made efforts to integrate malaria and covid surveillance systems.

**Sudan**

**Reproductive health is hit hard in conflict**

WHO and the United Nations’ sexual and reproductive health agency, UNFPA, warned that the continuing attacks on healthcare in Sudan were depriving women and girls of lifesaving healthcare. Two thirds (67%) of hospitals in areas affected by fighting are closed, and several maternity hospitals are out of action. Some 262 880 of Sudan’s women and girls are pregnant, and more than 90 000 will give birth in the next three months. Since April, when fighting began, WHO has verified 46 attacks on health workers and facilities that have killed eight people and injured 18 others.

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**SIXTY SECONDS ON . . . E-BIKES**

**A VIRTUOUS CYCLE?**

Not in this case. The New York Times has reported that batteries powering electric bikes have become a major public safety hazard. They’ve been blamed for causing fires in the city, killing at least 13 people.

**WHAT HAPPENED?**

On 20 June a fire started in an electric bike shop in the city’s Chinatown district and quickly spread up a six storey building, killing four people and critically injuring two others. Last month another fire in a flat in upper Manhattan left four people dead, and firefighters found the remains of several lithium-ion batteries from electric bikes.

**WHAT’S CAUSING THIS?**

Lithium-ion batteries can overheat while being charged and can explode in an extremely hot flare of flame. This, say experts, is because they contain a flammable electrolyte solution that allows electrical current to flow.

**WHAT’S THE SCALE OF THE PROBLEM?**

The New York City Fire Department says that 108 fires from lithium-ion batteries have occurred in the city this year. It believes that this is often caused by reconditioned batteries sold in a largely unregulated marketplace.

**SURELY LAWS MUST APPLY THE BRAKE**

New York is trying to lead on this issue, recently passing new regulations aimed at preventing battery fires. The new rules prohibit the sale, lease, or rental of e-bikes and electric scooters whose storage batteries fail to meet recognised safety standards.

**TAKING CHARGE OF THE PROBLEM**

One of the major causes of battery fires is overcharging. In new guidance released in response to the spate of deadly incidents, New York City Council recommends the use of outlet timers—devices that stop the flow of electricity from an outlet after a certain amount of time to prevent overcharging.

**ANY OTHER WHEELS IN MOTION?**

The guidance also recommends fireproof bags made of glass fabric woven with steel threads, which can hold batteries while charging and contain fires if they erupt. These are commonly used by bike shops in Europe and by airlines to contain battery fires.

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NHS crying out for investment, says new comparative study

The UK performs “substantially less well” than its peers on many critical measures of health status and healthcare outcomes, a study of 19 similarly developed countries has found.

It has below average cancer survival rates and life expectancy and “lags behind” in capital investment, with “strikingly low” numbers of doctors and nurses, relatively few hospital beds, and far less diagnostic equipment, says the analysis from the King’s Fund.

But the NHS does not need a new funding model because it has “strong foundations” and some distinctive strengths, including the generally low cost of access and high generic prescribing rates.

Rather, it is “crying out for investment” and improvement, with better long term planning and political support, to prevent more people dying early from diseases, say the authors.

The study looked at the NHS and health systems in 18 other countries—Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, the Netherlands, New Zealand, Portugal, Spain, Sweden, and the US.

The King’s Fund relied heavily on Organisation for Economic Co-operation and Development (OECD) data for the study, which was commissioned by the Association of the British Pharmaceutical Industry.

King’s Fund chief analyst and author Siva Anandaciva said that overall the study showed that the NHS was “neither a leader nor a laggard” and that the UK achieved “broadly average outcomes” for roughly

Workplace pressures are forcing doctors to leave medicine, GMC warns

Urgent action is needed to break the vicious cycle of unmanageable workloads and burnout that is causing doctors to quit medicine, the General Medical Council has warned.

The regulator’s report, The State of Medical Education and Practice in the UK: Workplace Experiences, warned that more doctors than ever say they are likely to leave the UK profession and had taken steps towards doing so (excluding doctors of retirement age, planning to retire).

The report drew its findings from a 2022 doctors’ survey, as well as qualitative research involving interviews with doctors, trainers, and stakeholders from UK healthcare organisations.

In 2022, 15% of the 6269 doctors who responded to the survey said they had taken steps to leave UK medicine, up from 7% of 3386 who responded to the survey in 2021.

In their foreword to the report, GMC chair Carrie MacEwen and chief executive Charlie Massey warned, “As clinicians vote with their feet, the gap they leave behind compounds workload pressures, feeding into a vicious cycle.”

In the short term, the report said it was “crucial to act immediately to improve working conditions
average spending on healthcare. Health spending per person in the UK is below average, while health spending as a share of gross domestic product (GDP) moved from being below average to above average during the pandemic. OECD data show that UK health spending was 9.9% of its GDP in 2019, 12.0% in 2020, and 11.9% in 2021.

**Life expectancy trails behind**

But the UK “trails behind its international cousins on some key markers of a good healthcare system,” Anandaciva said.

The UK has among the lowest levels of life expectancy for men and women. Since 2020, only the US has had consistently lower male and female life expectancy than the UK. The UK has higher levels of deaths from treatable diseases such as heart attack and stroke than most of its peer countries and below average survival rates for many major cancers, including cancer of the breast, cervix, colon, rectum, lung, and stomach.

The UK also has “strikingly low levels of key clinical staff” with fewer doctors and nurses per head than most of its peers, and a “heavier reliance on internationally trained staff.” It has just three doctors per 1000 people, while Greece has more than twice as many, with 6.3 doctors per 1000 people.

The UK also has relatively few hospital beds: 2.5 beds per 1000 people compared with an average of 3.2, placing the UK second to last out of 19 peer countries.

It spends less than many of its peers on physical resources such as buildings and equipment and comes bottom out of 19 countries for the number of computed tomography and magnetic resonance imaging scanners per person.

The UK health system does fare “relatively well” in protecting its population from the financial consequences of ill health or injury and on some measures of efficiency. It spends just 1.9%, the sixth lowest of the 19 countries measured, on health administration.

Anandaciva said spending on the NHS would have to increase substantially to deliver much better outcomes—from 3.4% average annual real terms increases to around 6-7%.

Abi Rimmer, The BMJ
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NEWS ANALYSIS

COVID-19 INQUIRY Experts clash with political leaders over effects of austerity

This week the UK’s pandemic inquiry kicked into gear, hearing evidence from high profile witnesses. Gareth Iacobucci summarises the key developments

Experts and medical leaders have heavily criticised the former UK prime minister David Cameron and his chancellor George Osborne after they denied that the austerity programme they implemented while in government had any adverse effects on the UK’s preparedness for the covid-19 pandemic.

Between 19 and 21 June the inquiry heard evidence from Cameron and Osborne, who were prime minister and chancellor from 2010 to 2016, along with Jeremy Hunt, the current chancellor, who served as England’s health and social care secretary from 2012 to 2018, and Sally Davies, England’s chief medical officer from 2011 to 2019.

Impact of austerity
Challenged by barrister Kate Blackwell about pandemic preparedness under their watch and austerity’s effects on the NHS, social care, and health inequalities, Cameron and Osborne issued a staunch defence of the agenda they implemented from 2010 onwards in response to the financial crisis that began in 2008.

Asked if he agreed that austerity had left the UK with “a depleted health and social care capacity and rising inequality,” Osborne replied, “I completely reject that.”

“If we had not had a clear plan to put the public finances on a sustainable path, then Britain might have experienced a fiscal crisis, and we would not have had the fiscal space to deal with the coronavirus pandemic when it hit seven years later,” he said.

Osborne’s contention that there was “no connection whatsoever” between austerity and the effects of covid being felt more keenly by the most disadvantaged people in society was described as “staggering” by the BMA’s president, Martin McKee.

“The removal of the social safety net, the cutting and reallocating of public health budgets, the underfunding of public services—all of this had its greatest impact on the most disadvantaged,” McKee said.

“Tens of thousands of excess deaths in the poorest areas were attributed to austerity policies even before the pandemic hit, with ill health among the key causes. Austerity left the poorest exposed to the worst of this catastrophe. In the decade after 2010 life expectancy in the UK hardly improved at all, lagging even further behind all other high income countries except the US.”

The BMA’s chair of council, Phillip Banfield, a consultant obstetrician, sounded a similar note. “I have seen at first hand the damage wrought by years of austerity and a failure to prioritise the nation’s health,” he said.

“The UK was severely on the back foot when covid took hold, and this proved disastrous—for the doctors I represent and the millions who suffered at the hands of the virus.”

Michael Marmot, professor of epidemiology at University College London and director of the UCL Institute of Health Equity, whose own evidence to the inquiry on 16 June stated that the UK entered the pandemic with “public services depleted, health improvement stalled, health inequalities increased, and health among the poorest people in a state of decline,” gave a withering response to the former Tory leaders’ denials.

“David Cameron’s ignoring of the evidence in his covid inquiry testimony was irritating. George Osborne’s was worse,” Marmot said on Twitter.

Restricted NHS funding
Cameron and Osborne also defended their funding of the NHS during the austerity period, arguing that, unlike other public services, health budgets went up in real terms.

Cameron said he did “not accept” that health budgets set by his government were inadequate or that they harmed the NHS’s ability to provide an adequate service leading up to the pandemic.

But in response online the Nuffield Trust’s Leonora Merry and Sally Gainsbury pointed out that the real terms increases in the NHS’s budget during the 2010s were effectively flat, given the rising demand. “Our own work, and that of many others, has indicated that austerity was a contributing factor to declining resilience in the NHS in the years leading up to the pandemic, hampering its ability to manage the shock of covid,” they wrote.

Banfield pinpointed workforce as a particularly crucial area of neglect.

“This failure to ensure the NHS was properly staffed and resourced in the decade leading up to the pandemic meant that, when it did arrive, there was no capacity to meet the tsunami of demand,” he said.

In her evidence Davies said the NHS’s system did not compare favourably internationally in terms of how resilient it was to a pandemic. “Compared with similar countries, per 100 000 population we were at the bottom of the table on the number of doctors, number of nurses, number of beds, number of ITUs, number of respirators and ventilators,” she said.

Hunt said he recognised

Kate Blackwell KC questioned the former PM and chancellor on the impact of economic policies on pandemic preparedness

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and agreed with Davies’s concerns and insisted he had tried to tackle them as health secretary by initiating increases in training places for doctors, nurses, and midwives and in the NHS budget. “I thought the NHS needed more capacity to increase the doctors per head to closer to western European levels. But . . . there was also a financial crisis, so it was going to take some time to address those issues,” he said.

“I think that we should be better at long term workforce planning,” he added.

Banfield, however, gave short shrift to Hunt’s evidence. “He blames poor workforce planning—as if he wasn’t in charge of health services for six of the last 11 years and as if he is not the one who now, as chancellor, has the power to fund the comprehensive NHS workforce plan that we are still so desperately waiting for.”

Too focused on flu
In their evidence Cameron, Osborne, and Hunt all admitted that the government made a mistake in focusing on preparing for a flu pandemic at the expense of other potential threats, leaving the UK exposed and vulnerable when covid hit.

Cameron insisted that the “architecture of planning and resilience” that he set up in 2010 to look at, judge, and plan for risks was robust but added, “The regret . . . is that more questions weren’t asked about the sort of pandemic that we faced.”

Hunt concurred, echoing comments he made in a 2021 interview with *The BMJ*, in which he acknowledged there was “groupthink” in the UK’s pandemic planning that meant that areas such as quarantining, community testing, and contact tracing, and stockpiling personal protective equipment and ventilators were neglected.

“We hadn’t given nearly enough thought to other types of pandemic that might emerge and that was, with the benefit of hindsight, a wholly mistaken assumption,” Hunt told the inquiry.

For example, Hunt said that during October 2016’s Exercise Cygnus—a cross government simulation to test the UK’s response to a serious flu pandemic—there was no reference to testing or quarantining because with flu there was no asymptomatic period.

“Those are not things that we put any energy into,” Hunt admitted.

Hunt said that, before covid, “there was a sense that, with perhaps the exception of the United States, there wasn’t an enormous amount we could learn from other countries . . . I don’t think people were really registering particularly Korea as a place that we could learn from.” He said it was “very notable” that South Korea, which had the experience of dealing with the MERS and SARS outbreaks, avoided a lockdown in the first year of the pandemic, because of its strategy of wide scale testing and quarantining.

Davies agreed that the UK and other rich countries were too focused on flu. “Clearly, we could have done more thinking. The system, which included me, needed more challenge,” she said.

During her evidence Davies also admitted that “no one thought about lockdown” during the planning process for future pandemics and that the UK should have balanced biomedical advice more with other factors such as education, the economy, and social cohesion.

“I don’t think we as a nation considered those issues effectively,” she said. “The damage I now see to children and students from covid and the educational impact tells me that education has a terrific amount of work to do. We have damaged a generation, and it is awful.”

Gareth Iacobucci, *The BMJ*

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**Women were not given details of vaginal mesh surgery or its risks, finds Scottish review**

Women in Scotland who underwent vaginal mesh procedures for stress urinary incontinence were given inaccurate information and were not told of the risks of the surgery, a case review ordered by the Scottish government has concluded.

The Transvaginal Mesh Case Record Review, moderated by Alison Britton, professor of healthcare and medical law at Glasgow Caledonian University, analysed more than 40 000 pages of records from 18 women who experienced life changing effects from the surgery.

Tension-free vaginal tape became available in the UK in 1998 and by 2001 was the most commonly performed procedure for stress urinary incontinence.

Some notes did not bear any relation to the surgery that occurred

More than 100 000 women across the UK had the procedure, but its use was halted in 2018 after it emerged that some women experienced painful side effects.

“Tape” was the term given to the implants by the industry that created them, and women hearing the term did not associate it with a polypropylene mesh device, the review found. Women were not told the size of the device, and only one of the 18 was told that this was a device which was designed to be permanent and not to be removed. None were shown an example of the device.

Once implanted, the mesh is very difficult to remove. Some of the women had operations to remove it and were wrongly told that it had all been removed.

The panel observed “a lack of clarity in the case records documenting the nature and potential outcome of mesh revision surgery. Some notes were misleading, but other cases did not bear any relation to the surgery that had occurred, nor its outcomes.”

The review called for a comprehensive register to keep track of women who have had operations to remove mesh in Scotland and elsewhere, including private operations.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2023;381:p1436

**MORE than 100 000 women across the UK had the procedure but its use was halted in 2018 after it emerged that some women experienced painful side effects**
Celebrating Windrush

On 22 June 1948 the Empire Windrush landed at Tilbury docks in London carrying 429 Caribbean people, many of whom went on to fill thousands of jobs in the NHS, which was to be founded just 13 days later.

Last week, the families of those first passengers celebrated with those who arrived later and became integral to the running of the health service.

Alison Shepherd, The BMJ

Cite this as: BMJ 2023;381:p1467
EDITORIAL

The NHS at 75

Profound chronic challenges demand serious and bold political leadership

Health systems everywhere are still reeling from the effects of the pandemic, a fact shaping short term policies and election manifests. But the consequences of covid-19 obscure profound chronic challenges that demand urgent attention from political and other leaders.

Nowhere in western Europe is this more pressing than in the UK’s NHS, made vulnerable by chronically low investment and hit hard by the pandemic. Many key health outcomes are worse than many comparable rich countries. Beyond its 75th anniversary on 5 July, what are the deeper issues to be tackled before the NHS’s centenary, and how should we respond?

Investment

Economic growth powers health systems. Overall, real terms annual growth in UK government total health investment averaged 3.9% in England between 1978-79 and 2019-20. But growth slumped to around 2% a year in the austerity decade preceding the pandemic. Social care flattened at best, and funding for public health has fallen by 26% per person since 2015-16.

Although the NHS was better protected than other public services, spending growth per person fell behind the EU-14 average by £40bn annually, and it shows. Projections by the Office for Budget Responsibility show the economy growing nearly 2% annually in real terms to 2027, yet health spending is set to rise by only 0.1% annually to 2024-25. Unless economic growth picks up, a bigger political appetite emerges for higher taxes or fiscal debt, or there are further reductions in spending on other public services, catch-up investment looks unlikely. Unlocking investment will need better evidence that health and social care are essential assets for economic growth and more public pressure.

Whatever happens, there will be an intense focus on productivity. Before the pandemic, the NHS’s track record seemed strong, in part down to a national squeeze on wages. This is now unsustainable, as industrial action across the NHS shows, and changes to working practices will need investment in technology and management. But capital spending (for facilities and expensive equipment) on healthcare in the UK has been lower than comparable countries for decades. Matching France and Germany’s spending as a share of gross domestic product would have added an additional £33bn to the NHS budget between 2010 and 2019.

To avoid a potential “doom loop” of low investment in the NHS leading to lower productivity and deteriorating performance, some economists are calling for the government to revise its debt based fiscal rules. These limit borrowing and restrict “public investment today to support growth and resilience tomorrow.” Imaginative thinking about funding for healthcare—for example, from appropriate commercial use of NHS data and research—might help but will be no replacement for government spending.

Demography, health, and demand

The UK, like many western European nations, is ageing fast. Between 2018 and 2028, the number of people aged 75 to 84 years in England is projected to jump by a third, and those over 85 by a quarter. By mid-2045 the population of pensionable age will grow to 15.2 million (up 28% since 2015-16), nearly one in five people in England. New projections indicate that, by 2040, there is a global shortage of health workers, and NHS trusts have 11 200 vacancies. Despite relying heavily on internationally trained workers, the UK has fewer doctors and nurses per head than the EU-14 average.

At the time of writing, the government was poised to publish its long awaited workforce plan. More staff will help, but retaining them is key—something policy
makers often forget. And realising their benefit will require investment in modern equipment, buildings, and IT. Under-investment has left the NHS short of vital equipment, such as MRI and CT scanners, and operating in dilapidated facilities, risking patient safety. There is no clear capital strategy, and the application and allocation system for providers is fragmented and opaque.

NHS beds have halved in number over the past 30 years to fewer than 150 000—among the lowest per capita in the Organisation for Economic Co-operation and Development. In part, this has been achieved through cuts in lengths of stay and high bed occupancy, which seem to have reached their limits. Bed supply might need to grow by 23 000 to 39 000 by 2030-31 to maintain current service levels.

Investment must also be rebalanced to better reflect population needs. Over the past 20 years growth in care has been directed to hospital services at the expense of primary, mental health, and community care. GPs in poorer areas are under-resourced than those in richer areas. The neglect of social care is unacceptable and preventing hospitals discharging frail older patients: at least £6bn extra might be needed annually by 2030-31 to keep up with demand.

Technology, skills, and research Scientific and technological development is one source of hope. Government investments in life sciences, supercomputing, and artificial intelligence include £650m to a “Life Sci for Growth” strategy—In part to speed up new treatments through clinical trials, strengthen preparations for future health emergencies, and increase capacity of the UK BioBank. These investments aim to boost economic growth, not to meet primary objectives for the NHS, such as improving care for people with chronic conditions and frailty, reducing inequalities, and achieving net zero. Current investment in life sciences, AI, and digitalisation might not meet these objectives without more powerful academic, commercial, or political backers to argue for them.

Policy making, reform, and change Polls consistently show strong support for the NHS model and deep concern about its state. Despite media commentary, there is no public appetite for radical change to its funding model. Politicians have instead focused on reforming the existing system, inevitably with political objectives. Some reforms have helped, but too many have not and have slowed progress. Given mounting pressures, can policy making as usual sustain such a large and critical national asset? If not, then what can?

The first step must be to secure broad (ideally cross party) agreement on the key challenges and the need for a coherent longer term and cross government programme to tackle them, with adequate investment. This is difficult, evidenced by chronic failure to reform social care, a history of structural reforms without a clear logic for how they will improve care, and myopia on the effect of austerity across the public sector on health and the NHS. Proposed solutions usually seek to change the NHS’s organisation—typically the size and scope of its planning bodies and degree of national oversight—or tweak policy levers like financial incentives, targets, or regulation. The effect of these changes is frequently overblown and closely tied to investment. Other responses have focused on strategies to improve clinical areas, such as cancer or mental health. But all these are partial and don’t tackle the systemic nature of what is ahead.

All western industrialised nations face similar headwinds. The NHS has uniquely powerful assets to support transformation in care: a single payer system with the ability to create coherent national strategy and coordinate services, cradle to grave data, public support, effective cost control, and a strong academic science base that can synergise with care services. Politicians should back the NHS model, use these assets, and focus on supporting staff and patients to redesign how care is delivered—not more structural changes that can damage and distract.

Directing science and technology to reshape care, particularly outside hospitals, will be key, as will cross-government action to improve health and support people to stay independent for longer. We need a fundamental reboot to policy, rather than reform as we’ve known it—serious bold political leadership is sorely needed.

Given mounting pressures, can policy making as usual sustain such a large and critical national asset?
Lifesaving yet frustrating, in need of transforming not dismantling—insiders’ reflections

Commissioners from The BMJ Commission on the Future of the NHS reflect on what the UK’s health service means to them—and how it will need to adapt to survive the next 75 years

Everybody is entitled to good health, but the NHS cannot achieve it in splendid isolation

Victor Adebowale, chair, NHS Confederation

My mum being a nurse makes the NHS’s 75th anniversary quite emotional for me. The NHS holds great social value and acts as the glue that brings us together. I’ve heard people saying that they’ve worked in the NHS for 40 years and have never seen it in such a challenging state. I’ve also witnessed many seeking alternative options. I question them, asking why they would want an alternative; some argue that we can’t afford the NHS and that it consumes a significant portion of the country’s gross domestic product. I counter by asking what else they would prefer to spend it on. It’s not about the amount we spend, but rather the value we derive from it. The NHS simply requires more investment in people, funds, and political will.

I’m not against change—we haven’t got the same population as 75 years ago—but it is crucial to maintain the current model. Three major problems need to be tackled: equity, access, and digitalisation. We need a workforce that cannot be bought

The BMJ Commission on the Future of the NHS

In its 75th year, the NHS has never been in a deeper crisis and, although the problems may seem insoluble, we believe that the central premise of the NHS—a health service free at the point of care for all the population—is worth fighting for. It is possible to create a vision for a society that prioritises outcomes related to health and wellbeing with the NHS at the heart of it. The purpose of our NHS Commission is to identify key areas for analysis and bring those together in a publicly available report by January 2024. Our commission will lay out that vision and make recommendations as to how we get there. https://www.bmj.com/nhs-commission

The largest human rights organisation in the world

Charlotte Augst, policy, strategy, and engagement leader

The NHS has manifested the belief that all humans have equal dignity and rights when it comes to falling ill—you could say it is the largest human rights organisation in the world.

We can have complicated clinical conversations about complicated clinical decisions without thinking that commercial motives are the driving force. Of course, the creation of the NHS promise is yet to be fully realised; it is human built and therefore not perfect.

My hope for the future is that the NHS will still be built on the core principle of its foundation but embedded in a much wider network of public service provision and community activity. Hospitals can’t go it alone and need to be part of a much more community-focused approach to population health management, as well as being invested in better service delivery and service design, to make themselves accessible and useful to everyone.

The NHS needs to join other conversations, with communities and other services using common tools such as multidisciplinary teams, shared decision making, shared visibility, and shared contributions to health and wellbeing. There is a disconnect between the quality of policy discussion and the quality of healthcare delivery, and it is important for service users to have a voice around the table both in design and delivery of healthcare.

To become a more fit-for-purpose service, the NHS needs to be clinically excellent but also know what it doesn’t do and can’t do. People’s needs are not bottomless—they need access, safety, dignity, and equality—but if the NHS tries to go it alone, there is a danger of overmedicalising the human experience. The system needs to bring more kindness, social connection, and human contact to those with health needs. It is important to invest more in prevention and to reverse the current trend of care that is over-focused on specialists and hospitals. Ultimately, everybody is entitled to good health, but the NHS cannot achieve it in splendid isolation.

It is vital to challenge conversation and mentality surrounding the future of the NHS and to put outcome based measures at the forefront. We know what changes are needed to create a sustainable healthcare system; we now need to find the will to put those changes in place.
As a patient, I bring 30 years' experience to the conversation

Emma Doble, patient editor, The BMJ

I'm so incredibly appreciative of the NHS: the system, the people, and everything that encompasses its founding principles. I was diagnosed as having type 1 diabetes when I was 4 years old, and since then the NHS has saved my life probably more times than I care to admit. I think the NHS is incredible, and I'm so thankful for its intentions—which I think are always great—but it's clear that we've got to a point, after 75 incredible years, where it isn't working as anyone would want—not patients, staff, anyone.

As a patient, it can be incredibly frustrating. I'm hoping that, through the BMJ Commission, we can open the doors of the NHS to patients, push for the value that patients add, and harness that through collaboration. Without patients, we don't have the full picture. The NHS is a system that has patient wellbeing as its end goal. Patients have to be involved.

We bring knowledge, skills, and expertise as much as our clinical counterparts do. I've lived with my condition for almost 30 years now—I bring 30 years' worth of experience. If I'd have studied this at university for 30 years, I'd be an expert in my field. There's no way we can consider what an NHS should look like without involving patients.

We should simplify medical education

Parveen Kumar, emerita professor, Barts and the London School of Medicine and Dentistry

Medical education and clinical academia will have a critical role in the NHS' development over the approaching decades. We should simplify medical education. Imagine a "generic" multidisciplinary first year designed for all student healthcare professionals. Then we could compress the rest into just two to three years, by having shortened holidays and producing basic doctors trained on a worldwide curriculum. The rest you can learn during clinical practice and specialty training. I also favour promoting graduate entry courses, as postgraduates have amassed study skills and maturity.

I dislike the idea of setting quotas in certain circumstances. The problem is that if you have a quota then people will say, "Oh, so you only got in because of the quotas." I promote women's rights, but women are nearly 60% of all medical students, and I think that's wrong as well. We need it 50:50, to reflect the population. Quotas could be acceptable in inequitable circumstances, and we do need doctors of all ethnicities and backgrounds. But if one must set quotas, then make sure that you have the capability to mentor them too.

Concerningly, women are very poorly represented in clinical academia at present; although many get into medical school, few reach the top. Men don’t understand that women do two jobs, as we are biologically responsible for childbirth. Especially now, doctors’ salaries can’t even afford childcare.

This commission has much to consider, not just the lack of funding—I think we’ve got to rethink what the NHS is for.
Q&A: Yvonne Coghill

NHS Race and Health Observatory adviser; former director of NHS England’s Workforce Race Equality Implementation Team

What’s your most treasured memory about or experience with the NHS?
My most treasured memory of the NHS is the one that I’ve just had after my husband became really sick: I will never forget how the nurses, doctors, porters, and cleaners were with him and with me. I was so taken aback by how wonderful everybody was, particularly as it was right in the middle of the doctors’ and nurses’ strikes. So they were all very stressed and going through a very difficult time. But actually, if I didn’t know that, I wouldn’t have known that. The most important thing was that he was getting good care, and they were also caring for me. And I will never forget that. His passing was as good as it could be because the NHS was there, and they were fantastic and wonderful. That’s something that will stay with me forever.

What do you think are the key accomplishments of the NHS over the past 75 years?
That the NHS has actually survived, that it’s still here after 75 years and is very powerful. People still love it even though it has its flaws. And it’s also one of our best loved institutions. I remember the Olympics opening ceremony in 2012 and it was wonderful to see all the nurses pushing the beds; the NHS is central to everything that is good about this country.

How might the NHS continue to excel and improve in the next 75 years?
The NHS needs to value its staff much more than it does. The people in the NHS are fabulous. People don’t work in the NHS to become millionaires; they’re there to care for people. And so, because the people in the NHS care for the population, the government needs to care for the people that work in the NHS. Even little things like free parking, for example, or making sure that they have water and decent breaks, making sure that they don’t work 12 hour shifts and then have to work another 12 hour shift and then work nights. And that will mean that they become even more compassionate to patients. Getting that extra discretionary effort because they are cared for is absolutely key.

How about the scope of the NHS and what role does it have in tackling public health challenges like mental health, obesity, and an ageing population?
Huge, huge, huge. Yesterday I heard that we’re going to be giving more people the drug to keep them slim [semaglutide], which is really interesting. The fact that the NHS says this is a good thing and it’s been quality assured means that people will take it. The NHS is so well respected, and people do listen to advice. We’ve reduced smoking exponentially because the NHS took the bull by the horns and pushed to stop smoking. We did the same with HIV and AIDS. It’s the same thing with covid. You know, we can do this as an organisation. We can actually get people to start listening.

Why is it crucial to preserve and protect the NHS?
I can’t imagine this country without the NHS. What would we have if it wasn’t there? I mean, people can hardly afford to feed themselves these days, let alone pay for their healthcare. The inequities would open up gaping holes if we didn’t have our NHS. You see this already with teeth, people can hardly afford to feed themselves these days, let alone pay for their healthcare. The I can’t imagine this country without the NHS.

Are there any specific areas in the NHS that you fear are going to become underfunded and neglected in the future?
We’ve had all these reports on maternal health over the past couple of years, and it is something that really needs to be looked at. We also need to do something about mental health, of course. One in two of us will get cancer. That’s the reality, and we really need to be focused on this.

I’d like a healthcare system where intensive care isn’t required

Matt Morgan, intensive care specialist

There are three key areas for the NHS to focus on: prevention rather than care, evidence based medicine, and staff retention.

Prevention is key: the best way to survive intensive care, where I work, is to not go to intensive care. I’d like a healthcare system where intensive care isn’t required: when I’m unemployed, that’s a success. While unobtainable, it’s still something we should strive towards. A lot of our workload is the acute side of chronic disease, preventable by high quality management. But it also lies deeper than that, as diseases are often the end result of the wider determinants of health.

All NHS healthcare delivery should be evidence based, and if it’s not, then it should be evidence generating. Right now, although the NHS is one of the biggest data producers worldwide, we don’t effectively use it. Evidence based policies might assist staff management: beds don’t care for people, people care for people, so it’s the staff that we also have to care for.

Which brings us on to staff retention. Full pay restoration is a start, but life isn’t all about pay. There are many cost neutral options in improving conditions, such as fortnightly pay cycles, long service leave, built-in study leave expense payment, and the removal of punitive pension tax charges. Additionally, life is also about people and culture, a critical “home field” advantage for the NHS.

Individually, we don’t know what reforms are right or needed, but together, as a multidisciplinary commission, we get the time to consider the most important questions in the NHS.

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It’s widely acknowledged that the NHS is “in crisis” in both England and Wales. Are there differences in approaches between the two countries—and, if so, is that showing any divides in performance improvement? Published performance data differ considerably, but show undeniably that both are failing to meet patients’ needs and demands. Underfunding by the UK government (see box below) is blamed as the key cause of the common problems including long elective waiting lists, emergency waiting times, and ambulance response times; recruitment and retention; and, of course, pay.

Pay

The BMA in England has rejected the pay offer, junior doctors have just gone on strike for the third time this year, and consultants are being balloted over whether they also wish to strike this summer. Meanwhile, BMA Cymru Wales is still in talks with the Welsh government and doctors have not yet been balloted about any offer. Eluned Morgan, minister for health and social services in Wales, says the Welsh government is committed to the principle of restoring NHS staff pay to 2008 levels. Most health unions in Wales, with the exception of the Royal College of Nursing and the Society of Radiographers, accepted the Welsh government’s enhanced deal, which offers an additional 3% on top of the pay review body’s recommendation for this year.

Last July the Review Body on Doctors’ and Dentists’ Remuneration recommended a 4.5% uplift for doctors eligible for a 2022-23 pay award in Wales that included consultants, doctors in training, and specialty doctors and some associate specialist doctors.

“The additional 3% offered, which will be backdated to April 2022, comprises a 1.5% consolidated pay rise, meaning that it will be a permanent pay increase, plus a 1.5% non-consolidated rise, in effect a one-off payment for this year. The offer will apply to all doctors in secondary care, as well as other hospital staff, but not GPs,” Morgan says.

The package includes non-pay elements, including a commitment to support the full implementation of the BMA’s fatigue and facilities charter to improve the safety and wellbeing of doctors at work. However, Iona Collins, consultant orthopaedic spinal surgeon and BMA Welsh Council chair, says these elements “are aspirational and something we continue to work towards—but the most tangible improvement within the Welsh and UK governments’ gift is to increase pay.”

She calls the enhanced package “a stop gap measure” that nobody is happy with. The BMA’s goal is pay restoration, she adds—which doesn’t just mean getting pay back to 2008 levels, but keeping up with inflation and putting an end to its erosion.

Recruitment and retention

Collins continues, “The purpose of full pay restoration is to incentivise staff—not only to remain in the NHS but to return to the NHS as well.”

“We are vulnerable because our available GP workforce is pushing retirement and we are

**INVESTMENT PER CAPITA**

The BMA report *Health Fund Data Analysis*, published on 6 April, found that healthcare spending is “uneven across the UK” and has not increased enough to keep up with demand.

“In the five years before the pandemic, healthcare spending per person was lowest in England compared with each of the UK nations and spending in Northern Ireland was highest,” it says.

Healthcare spending per person increased significantly in 2020-21 because of additional covid funding. Spending in Wales rose from £2910 per person in 2019-20 (when it had ranked second in the four nations table) to £3468 in 2020-21. England, which had ranked fourth, rose to third place when it increased its spend from £2776 to £3514, knocking Wales to the bottom of the table. Northern Ireland remained top at £3724, and Scotland jumped from third to second place with £3724.
not incentivising newer qualified GPs to remain in primary care.”

Improving trainee doctors’ pay and levelling up financial support for professional training with trainees in England would be a strong incentive to stay in Wales, says Georgina Budd, a GP registrar in the Rhondda Valley town of Mountain Ash, and co-chair of the BMA Wales Council junior doctors committee.

“The basic pay of a foundation year 1 doctor in England, including specialist and GP registrars, is £29 384 compared with £27 115 in Wales, the BMA says. Neither do junior doctors in Wales get the same level of allowances for training courses, exams, and registration fees needed to continue and further their careers. They receive a lower pay rate—£13 an hour in Wales compared with £14 in England—according to the BMA.

“I want to stay in Wales and I still love my career, but I have thought about potentially living abroad or having an alternative income stream,” says Budd. “To increase recruitment and retention, Wales needs to be a good place to work.”

NHS England says that workforce data published in May showed that more doctors, nurses, and staff than ever before are working in the NHS: over 500 more full time equivalent doctors are working in general practice compared with a year ago and over 1.28 million full time equivalent staff are working in NHS trusts and commissioning bodies in England as of March 2023—over 53 600 more compared with a year ago, an increase of 4.6%.

NHS England previously announced the appointment of more than 29 000 additional primary care staff, delivering on its commitment to recruit 26 000 more staff in primary care by March 2024.

But Nuffield Trust researcher Lucina Rolewicz says, “Given a rising budget and a growing population, you would expect NHS staff numbers to grow steadily. But patients might wonder why the health service continues to struggle with waiting times and access to general practice far worse than we saw a decade ago.”

She warns, “For some staff groups the longer term trend looks less rosy, with GP numbers still below where they were in 2015. There is a risk that rapid recruitment matched with a recent peak in staff leaving is creating a workforce with more turnover, damaging morale and losing experience.

“Stress and burnout may mean staff cannot sustain the same workload—and pharmacists, nurses, and navigators cannot perfectly substitute for GPs. The service now needs to understand how to deploy the right combination of staff to turn these rising numbers into real improvements for patients.”

Sarah Clarke, president of the Royal College of Physicians, adds, “It’s demoralising for staff to keep seeing ‘record numbers’ of staff headlines when, for so many of them, their reality is feeling burnt out from doing the job of two or three people.

“It’s true in simple terms that there are more doctors than ever before. But it’s also true that more people need more care than ever before, and there are more NHS vacancies than ever before—around 9000 in medicine alone.”

The future

New and innovative ways of working as well as investment are needed to transform the NHS either side of the border. There is no shortage of plans and proposals.

NHS England published its elective recovery plan in February 2022, a blueprint to tackle backlogs built up during the pandemic and long waits for care with a massive expansion in capacity for tests, checks, and treatments. It set a target of eliminating waits by March 2025, saying a 30% increase in capacity would be needed to achieve it. Some 10 000 patients were waiting 18 months as of March 2023.

A diagnostic recovery and transformation strategy for Wales for 2023 to 2025, after the end of the acute phase of the pandemic, was published by the Welsh government in April. A Royal College of Physicians Cymru Wales report, Under pressure: collaboration, innovation, and new models of integrated care in Wales, sets out findings and recommendations from a joint workshop between regional partnership boards, royal colleges, and other professional bodies. And a £30m scheme to boost care in the community to help cut waiting lists was launched by Welsh government on 6 June.

Collins believes the NHS can and will survive—in Wales, at least. She says, “What excites me about living and working in Wales is that we have a small population and a government that is devoted, and so we have the ability to work together and demonstrate to the rest of the country how to run a health service properly.”

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