THE NEW STATESMAN

Spotlight

Thought leadership and policy

Healthcare: Wes Streeting's to-do list

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THE NEW STATESMAN

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To govern is to choose

From fixing outdated digital infrastructure to combatting health inequalities, meeting climate change obligations, alleviating pressure on social care and addressing the needs of an ageing population, how does the new government make sure healthcare is fit for purpose in 2024 and beyond? And how does it choose what do to first?

That is the focus of this edition of *Spotlight*. For the Health and Social Care secretary, Wes Streeting, it represents – figuratively and, perhaps, literally – a long, arduous to-do list.

To understand the scale of the crisis in the health service in England, consider that one in five adults are now waiting for NHS care.

As we ask on page 8, "What's wrong with the NHS?" The answer is plenty.

Digital technology is often cited as a something of a cure-all, both a means of driving greater productivity and – and in part as a consequence of the former – delivering better care.

Typically, the language of IT is heightened. Earlier this year, then chancellor Jeremy Hunt discussed "harnessing new technology", while last month Lord Darzi – in his government review of the NHS in England – called for "a major tilt" towards IT. As far back as 2005, a Cabinet Office Report commissioned by then prime minister Tony Blair insisted that 21st-century government is "enabled by technology". And while it may be true that technology can enable, there is no guarantee it will. There are plenty of examples of when it does not (see page 18). Those in healthcare, more than most, know that it is best to approach the promise of a panacea with scepticism.

To focus on the NHS alone would be to miss some of the underlying causes of ill health. As Michael Marmot and Jessica Allen, two of our expert panel on health inequalities (see page 26), observe: "The scale of excess mortality cannot be explained by the crisis in the NHS, important as that is, but is closely linked to the social determinants of health – all affected by austerity."

Meanwhile, Andrew Dilnot, who has advocated for social care reform for more than a decade, remains frustrated but not defeated (see page 14). He still believes the decision taken by Chancellor Rachel Reeves to delay his proposed lifetime cap on care costs is a "tragedy" but is confident that common sense will prevail. "We talk about the burden of ageing as though it's bad to live longer... It's bizarre." ●

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THE NEW STATESMAN
EVENTS

NS Future of Healthcare Conference
29 October London

The *New Statesman*'s Future of Healthcare conference is an annual event addressing the country's most pressing policy issues in health and social care.

Through panels, live interviews, speeches and debates, you will hear insights from experts, politicians and industry leaders. The 2024 conference will examine issues across health and social care, including life sciences, health inequalities and the UK's increasing ageing population.

This year began with the NHS facing a number of unsustainable pressures, including record-high waiting lists, staff shortages and insufficient capacity to meet the needs of patients. However, with a new party in power, the government is now driving forward a new healthcare agenda with NHS reform at the centre.

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Topics for discussion include:

- Progression through prevention: How can we build a healthcare system that is fit for the future?
- How can life sciences R&D drive innovation and improve patient outcomes?
- How can we tackle health inequalities and support people across the UK to live better, longer lives?
- Future proofing the UK health and care system: Tackling the health challenges that come with an ageing population
- Let's get digital: How can new and innovative technologies accelerate treatments and improve healthcare provision?
- Greener health: How can a net zero future transform UK healthcare?

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The view from parliament

Helen Morgan MP
Liberal Democrats health and social care spokesperson

"On social care, never have so many words been spoken and so little change delivered"

The Conservatives have left our country in a real mess. After years of mismanagement and incompetence, our NHS and social care services have been driven into the ground.

Labour's inheritance is a country where more than six million people are still waiting for elective treatment – double the number in 2015 – and in which we have some of the worst waiting times on record for cancer services.

As GP surgeries are overwhelmed due to poor funding and staff shortages, many patients are turning to A&E in desperation when they can't get the treatment they need.

People facing an emergency are driving their loved ones to A&E instead of calling for an ambulance they fear won't arrive in time.

The damage to our services goes even deeper than waiting times and poor outcomes. The condition of the NHS estate is dire too. Crumbling roofs, dangerous concrete and life-expired buildings blight our health services.

I am under no illusion that it will take time to repair the damage the Conservatives have inflicted on our health and care services.

Labour has made a start and I appreciate that the situation is dire – but with social care and health services in crisis, more is needed and it is needed now.

My party laid out our vision for health and care services at the election, and it is now our job to ensure that Labour effectively tackles the huge task of repairing the damage done by the last government.

The public want to see action now. They voted for the Liberal Democrats in large numbers because we put forward a compelling vision for our country's health and care services. When YouGov polled the popularity of all the policies in the major parties' manifestos, the top three were Liberal Democrat policies. All three related to health and social care. These were our pledges to boost cancer survival, ensure everyone can see their GP when they need to, and to implement free personal care which would ensure that patients can see a medical professional when they need to and get care and treatment on time.

We welcome some early initiatives from the incoming government. Increasing pay for health workers was long overdue and necessary.

However, Labour needs to rethink its approach to social care. Never have so many words been spoken, and so little change been delivered, on such a vital issue.

Not only do we need action to fix a social care system that just isn't working as it should; we need to support the millions of unpaid carers who have long been forgotten by government. People caring for their loved ones, often family or close friends, save the UK billions of pounds in care costs.

Liberal Democrats have a whole list of ideas to fix the crisis in care, and we were the first party to have a chapter in our manifesto dedicated entirely to care and unpaid carers. We put forward several policies that could be implemented straight away. These included our call for a Carer's Minimum Wage, set at a higher rate than the current minimum wage, and our pledge to establish a Royal College of Care Workers, to give these professionals the recognition and career progression they deserve.

Sustainable funding for social care is critical to any reform of the sector and we are ready to see Labour reach across the aisle and work with us to deliver the change millions of people need.

I believe Labour are serious when they say they want to clear up the mess left by the Conservatives. The time to get started is now. ●

MARTA SIGNORI

Advertorial

Tackling cancer waiting times

There's no silver bullet. But collaboration is key.

By Benson Fayehun

In association with

Following a cancer diagnosis, starting treatment quickly can save patients from feeling additional, unnecessary stress and anxiety. Yet, we know that many cancer patients in the UK are being forced to wait an unacceptably long time.[1]

Waiting times – an issue of inequality

NHS England has a target that at least 85 per cent of patients should start their first treatment for cancer within 62 days of an urgent GP referral for suspected cancer. Shockingly, this target has not been met since December 2015 and performance continues to deteriorate.[2]

Analysis by Cancer Research UK has found that certain characteristics indicate the likelihood of a patient waiting longer for treatment, with longer waits more likely for people in the most deprived areas.[2] The link between deprivation and increased waiting times is especially significant for certain types of cancer.[2]

The new government has committed to getting "a grip on the record waiting list"[3] within the NHS. This is an important ambition. But how do we reduce waiting times and how are pharmaceutical companies, like MSD, helping?

Starting the clock

The NHS emphasis on improving early diagnosis has started to pay dividends.

For example, the targeted lung health check scheme in England has led to 76 per cent of lung cancers in those tested being caught at an earlier stage.[4] This is crucial because it has one of the lowest survival rates, largely due to – historically – it being diagnosed at a late stage when treatment is less likely to be effective.[4]

But early diagnosis is the first step.

Time to treatment

Cancer Research UK has found that the most common reasons that patients who have been waiting for treatment have their first treatment delayed is shortages of beds or chairs, or low staff capacity.[2]

A survey by the Royal College of Radiologists of clinical radiology directors found that 97 per cent believe workforce shortages cause delays.[5] Radiology departments are not receiving enough funding to meet treatment demand.[6] Without additional resources, clinicians must make difficult choices, rationing care.[6]

Innovations in cancer treatment mean genomic and biomarker testing is often required to determine the best course of

treatment. Yet, depending on the cancer type and test required, there is variation on turnaround times.[7,8] What's the cause?

The reality is the NHS currently does not have adequate capacity to turn around testing and initiate treatment in a timely manner for all patients.[9] It is critical that the NHS finds a way to rapidly increase its capacity.

Closing the data gap

Data is essential to identifying blockages in the pathway, yet there continues to be an absence of high-quality data.

For example, even though triple negative breast cancer (TNBC) is an aggressive disease with a high recurrence and mortality rate[10], there is little accurate data on it in England. Studies from the US indicate that TNBC disproportionately affects black women,[11] data which enables organisations to offer tailored support. But in England we don't have the numbers.

By collecting and publishing data on all cancer types, including the time taken for each step in the pathway, the NHS could be better equipped take more informed steps to improve pinch points.

Playing our part

Without collaboration, the government can't bring down cancer waiting times. At MSD, we are actively working with the NHS on new strategies which enhance capacity and support patients to receive timely care.

We have dedicated teams who co-create bespoke projects with the NHS. This includes supporting NHS hospitals to implement improved cancer pathways, tailored to any challenges that local health services may have been facing to support better management.[12]

We are also collaborating with the NHS to build models of cancer treatment services, helping cancer services to better plan for current and future demands. We do this by building a model of local cancer treatment services, identifying key issues and adjusting parameters to make it meaningful to the NHS hospital trust.[12]

These projects are designed specifically to improve patient pathways and expand capacity to reduce cancer wait times, reducing inequalities.

Cancer care fit for the future

The new government has a massive opportunity to reduce waiting times and tackle health inequalities. Achieving this will take dedicated focus from politicians, the NHS and the cancer community, including pharmaceutical companies. We at MSD are committed to playing our part. ●

PHOTO BY MSD

Benson Fayehun is Head of Oncology Business Unit at MSD. This article has been paid for and developed by MSD. Job bag: GB-NON-10150. October 2024

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Diagnosis

What's wrong with the NHS?

The new Health Secretary has a long to-do list

By Jonny Ball

Nigel Lawson, Margaret Thatcher's longest-serving chancellor of the Exchequer, once said: "The NHS is the closest thing the English have to a religion." If that's the case, then perhaps the religion is in need of a Reformation, because the English are becoming more agnostic and less evangelical. (The healthcare systems in Scotland, Wales and Northern Ireland are run by devolved assemblies, but are in no less of a sorry state.)

And who can blame the public for its loss of faith? Even before Covid-19 hit the UK in 2020 and battered our health infrastructure, the service seemed to be locked into steady decline. In 2010, there were around 2.5 million people waiting for NHS in-patient treatment. By 2020, before the pandemic, that had risen to 4.5 million. Since coronavirus hit, and

The Health Secretary Wes Streeting launches an NHS campaign in Worcester in May

GETTY IMAGES / CHRISTOPHER FURLONG

elective surgery was delayed and postponed to make way for patients with the virus, the waiting list has ballooned to more than 7.5 million. One in five adults are now waiting for NHS care.

To understand the scale of the challenge that the Labour government faces – and to appreciate the length of Health Secretary Wes Streeting's to-do list – it's important, first, to understand the context. Fixing the NHS requires a detailed diagnosis and an examination of what policy choices got us into the state we're in.

We used to think of the National Health Service as the envy of the world. But figures from the King's Fund, a health charity, show that health outcomes in the UK are poor compared with other nations. We have higher avoidable mortality rates, driven by below-average survival for many major types of cancer, as well as poorer outcomes from heart attacks and strokes.

France and Germany have two and three times as many hospital beds per person, respectively. The same research from OECD data found we had fewer doctors per capita than any of our western European neighbours, and fewer nurses than all but Portugal, Italy and Spain – countries with less economic heft and much lower spending power.

The raw numbers obscure what this means in practical terms, on the ground. Tens of millions of sleepless nights due to chronic pain. Tens of millions of workdays lost due to sickness and ill health. Extreme discomfort, worry, stress and unnecessary agony. There were around 10,000 excess deaths last year. In 2022, there were around 50,000. That means 60,000 premature funerals over two years, with 60,000 families grieving earlier than they should, missing precious years of life. Many analysts have laid the blame for persistently high mortality at ambulance waiting times, treatment delays, and queues at A&E.

Upon founding the NHS during the Labour government of Clement Attlee, Nye Bevan, the titan of the postwar Labour left and Attlee's health secretary, said that "illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community".

The principle of a universal health service, paid for through general taxation and free at the point of use, was a cornerstone of the British welfare state. The NHS survived the monetarist, free-market privatisations and ▸

◂ deregulatory tides of the last 40 years, even as many of the other pillars of the social democratic consensus came tumbling down. But today, thousands are taking out loans for medical treatments rather than languishing on waiting lists. Some diagnosis companies are even offering treatments and directing people to Klarna – the controversial buy-now-pay-later app. The UK's second-most treasured institution (after the fire brigade) creaks under the weight of demographic pressures, an ageing population and much else besides.

Where did it all go wrong?

Some think they can pinpoint a specific year – 2010. David Cameron's government always claimed it would "cut the deficit, not the NHS" in an austerity drive aimed at returning the budget to surplus (something that was never achieved). In real terms, health spending was protected from the programme of fiscal tightening implemented by the chancellor George Osborne across the rest of Whitehall's departments. However, the headline figures obscured what was happening beneath the surface.

Money and structure

A recent review led by the cross-bench peer and academic surgeon Ara Darzi looked in detail at the performance of the NHS. Published in September, it found that the NHS is in a "dire state". Healthcare spending may have risen steadily in absolute terms under the coalition government and since 2015 but it has still been the most austere decade since the service's founding in relative terms. Real-terms budgets have risen just 1 per cent a year, compared with a long-term average of around 3.4 per cent a year. Adjusting for population growth and age structure, spending has virtually flatlined.

Money isn't everything. It matters – a lot. But the shape and governance of institutions also matter. Personnel matters. This is especially so in an unwieldy monolith such as the NHS, the largest employer in Europe, and one of the largest in the whole world. Paramedics, doctors, nurses and auxiliary staff have seen their real take-home pay deteriorate, contributing to a service-wide staffing crisis and mass emigration. The most popular destination for healthcare staff, particularly of doctors, is Australia.

Despite promising to "stop the top-down reorganisation of the NHS", Cameron passed one of the most sprawling, wholesale NHS reform packages in the service's history – the 2012 Health and Social Care Act. The *British Medical Journal* called it "unintelligible gobbledegook", and Shirley Williams, leading the Lords' opposition to the bill on behalf of the Liberal Democrats, said it was "so incomprehensible, so detailed, so long, [and] impossible to understand".

The bill entrenched the internal market and competition between trusts, reducing the influence of the Department of Health and Social Care. In doing so, it created an alphabet soup of arms-length bodies such as the NHS Commissioning Board; Public Health England; clinical commissioning groups; the NHS Trust Development Authority; Monitor, a new regulator; and dozens of competing, financially independent foundation trusts. It all served to facilitate more public commissioning of private provision and the bidding for treatments and medical services under the NHS umbrella.

"Big, top-down reform programmes distract NHS attention," Chris Thomas, head of the Institute for Public Policy Research's Commission on Health and Prosperity, tells *Spotlight*. "It had the NHS essentially breaking itself up and reorganising itself... distracting the system and taking capacity away from delivering patient care."

The bill was such a disaster that the health service only got through the pandemic by more or less abandoning its provisions, according to Dr Richard Murray of the King's Fund. Speaking to *Spotlight* after the first lockdown, he said: "It really did ignore the 2012 act by coming together. Organisations were swapping staff, swapping resources and moving patients around... They didn't compete – they cooperated."

But problems with the bureaucratic, market managerialism imposed in the 2010s are not the whole story.

> "It will take 15 years to get out of the mess we're in"

Capital spending

While day-to-day NHS running costs – spending on medicines, wages, electricity bills, everyday expenses – grew year-on-year even through the years of Osbornomics (and under Osborne's almost equally parsimonious successor in the Treasury, Philip Hammond), the amount the government spent on capital fell dramatically. These are the longer-term investments – fixed assets such as buildings, machinery, computer systems, digitisation, laboratories, heavy equipment and the NHS estate – that increase capacity and improve productivity.

The Darzi review identified a £37bn capital spending shortfall over the past 15 years, which the NHS Confederation summarised as being one of the key reasons for the NHS's "critical condition", along with "the negative impact of the coalition government's NHS reforms".

"This is to some extent mirrored across the UK economy," says Mark Dayan, a policy analyst at the Nuffield Trust, an independent health think tank. Multiple diagnoses of the UK's economic malaise and productivity puzzle, from think tanks, economists and assorted experts, have consistently identified chronic underinvestment by both business and government as a key source of our relative decline. The theme is repeated so often that it's hard to even call it a puzzle any more: growth is anaemic and living standards have flatlined because we don't spend anywhere near enough on increasing our productive capacity. This is a problem that applies across the economy, and the NHS is not excepted.

"We invest much less than any European or comparable countries," Dayan tells *Spotlight*, "so stuff like the number of scanners is very low, the number of beds... and also the NHS has quite old buildings, with big, shared wards, and those buildings are often in a very bad state."

Darzi's report revealed significant capital underspend as well as capital budgets raided to cover day-to-day running costs throughout the decade leading up to Covid.

The NHS has been hit by strike action from several unions

CARL COURT / GETTY IMAGES

Social, primary and community care
Leaky roofs, ancient IT and out-of-date machines might be enough to deal with but hospitals are contending with external pressures, too. These are arising from separate but related crises in social care and primary care – and make additional demands on a service in which supply is already constrained. Social care, which falls under the responsibility of local authorities, was the subject of major cuts in the 2010s. Central government contributions to council budgets were drastically reduced in real terms, sometimes by more than half.

Some of this was recouped in higher council taxes, business rates, privatisations and councils' commercial business ventures (which sometimes failed spectacularly). But core spending power remains constrained. If you've noticed potholes, closed libraries, closed sports centres, dirtier streets, cancelled bus routes, overgrown parks and an altogether shabbier public realm, that's likely because more and more of your council's budget is taken up by statutory spending on social care and children's services, usually around 65 per cent. Councils cannot cope.

"We've had this kind of row-back on everything that keeps the population in good health and stops people needing the NHS," says IPPR's Thomas. Home visits, residential care and meals-on-wheels, among all kinds of services, have also faced significant cuts. That means "patients no longer flow through hospitals as they should", according to Darzi, with 13 per cent of NHS beds occupied by "people waiting for social care support".

Primary care, or general practice, is also in a state of disrepair. "It's been under strain for a long time," says Nuffield's Dayan. "GP numbers for most of the last 15 years were going down, which given that the population was growing and getting older on average was an incredibly difficult situation."

People are finding it much harder to get doctors' appointments. GPs act as the gatekeepers for the whole system. But there's a huge primary care bottleneck. Unable to see their local practitioner, and with continuity of care increasingly rare, many are instead letting health issues fester, making them more expensive to treat. Some are presenting in hospital at a much later stage, when the cost of treatment dwarfs the outlay that would have been involved for an earlier, community-based solution or early intervention by a family doctor. The Royal College of General Practitioners also reports that the share of health spending going on primary care is at its lowest level in eight years.

On top of all that, across the UK stagnant real wages, changes to the benefits system and a broken housing market all come with their own sets of health demands: almost half of primary care services now run a food bank.

Staffing and prevention: green shoots?
The new government has grand plans for the health service under the ambitious Streeting. Already, it has attempted to halt waves of strikes and negotiate pay settlements with NHS workers, hopefully beginning to stem the staff exodus and bring waiting lists down. Streeting promises a renewed focus on prevention to reduce demand, as well as claiming that only Labour can be trusted to push through radical reforms, "just as only Nixon could go to China".

But some alarming noises from the Treasury indicate that capital spending could be subject to further restraint by the Chancellor, Rachel Reeves. We're being treated to mixed signals. The budget on 30 October is incredibly significant, for the country and the health service. Seeing a Labour government (with a former Bank of England economist in No 11) putting the squeeze on services because of an orthodox attachment to tight fiscal policy that not even the gilt traders and fund managers share, would provoke a serious question: what is a centre-left administration actually for?

"I do have sympathy with the idea that it took 15 years to get into this mess," says Thomas – "and that it might take 15 years to get out of it." ●

Advertorial

The right deal for all

Workers' rights reform is coming. Now is the time to unlock productivity and drive economic growth

By Mark Till

In association with

In recent years – following the pandemic, strikes and the cost-of-living crisis – the conversation around workers' rights in Britain has become increasingly pertinent. A consensus has largely been formed: that as the economy evolves to include new ways of working and emerging industries, the relationship between employees and employers must also evolve. Improving workers' rights isn't just a matter of social justice; it can lead to enhanced productivity, higher employee morale, and, ultimately, a more robust economy.

Workers' rights encompass various aspects, including fair wages, safe working conditions and job security, among other benefits. When these rights are upheld, employees can perform at their best, leading to increased efficiency and innovation. There are three particularly notable benefits to employees: increased job satisfaction; improved physical and mental well-being; and increased skills development.

The research backs this up. Unum has undertaken research on the mutual benefits a change to the status quo could have for both employees and employers. We take our role championing this cause seriously.

Last year, we commissioned the independent think tank WPI Economics to carry out research with over 4,000 employees. The findings were insightful. The research suggests that employees who are happy at work take, on average, nine fewer sick days per year compared to employees who report being unhappy, suggesting that health and happiness at work really does reduce sickness absence. Secondly, 80 per cent of employees reported that they are more productive at work when they are feeling healthy and happy – indicating that health and happiness at work are key drivers of productivity. Furthermore, employees who have good physical and mental well-being are nearly two and a half times more likely to be happy at work than those with poor physical and mental health – again, highlighting how physical and mental well-being are central to employee happiness.

There are also benefits to businesses from better working conditions. A happy and healthier workforce is one that has employees who are less likely to need to leave their jobs due to long-term sickness. They're much more likely to want to stay both in their current role and more

generally in work. In research commissioned by Unum, over half of the employees surveyed – representing more than 16 million people in the UK workforce as a whole – said that improvements in health and well-being offerings provided by their employer would lead them to take less time off and/or increase their productivity. When employees are not constantly worrying about job security or unfair treatment, they can focus their energy on achieving organisational goals. Additionally, organisations that uphold strong workers' rights often enjoy a better reputation in the market – which can help attract top talent and can also lead to improved customer loyalty.

The ripple effect from reforms to workers' rights to create a happy, healthier, and more productive workforce is clear for all to see. It is encouraging to see that the new Labour government is aligned on this. Announced long before Labour took office, its "New Deal for Working People" proposals include reforms to areas such as statutory sick pay, enforcing safe and healthy workplaces and encouraging a fulfilling work-life balance. The upholding of Labour's commitment to bring forward the legislation on workers' rights reform within the first 100 days of taking office is extremely encouraging.

Angela Rayner, the Deputy Prime Minister and Housing Secretary, has been forthright in connecting how a better deal will not only benefit employees and workers but also help drive economic growth – the central mission of the Labour government. The key component of the New Deal is the commitment to raising wages, particularly for low-income workers; not only could this lift people out of poverty, but it could also increase consumer spending, which can stimulate the economy. Additionally, the New Deal's aim to boost employee and skills training goes a long way in ensuring that employers have a workforce that is well equipped to meet the demands of a changing economy, in turn also boosting productivity and fostering loyalty.

As Rayner encouragingly said in an August meeting with businesses and trade unions at the Department for Business and Trade: "Our plan to 'Make Work Pay' will bring together workers and businesses, both big and small and across different industries, for the good of the economy." In addition to meeting the economic growth aspirations of the Labour government, simply put, a healthier and happier workforce will go a long way in meeting another one of the government's missions: to have a healthier nation.

ISTOCK

Unum's research links better working conditions to happy and productive employees

A report released in September by the Institute for Public Policy Research (IPPR) set out to explore the relationship between our health and our economy at a time when Britain is facing decline on both fronts. It supports many of our beliefs and outlines ten policy recommendations to add ten years to our population's healthy life expectancy over the next three decades – notably a focus on healthy work and workplaces, appropriate work support after we fall sick, and meaningful access to products that support our health. Researchers found a "strong association" between job quality and health – focusing on pay, contractual security, flexibility, autonomy, job satisfaction and well-being.

Our research showed that boosting access to health and well-being services at work, alongside halving the number of unhappy employees, could see companies collectively benefit by £6.4bn a year through reduced lost output from sickness absence and presenteeism. On top of this, increasing productivity as a whole could benefit companies by an additional £7.3bn per year. As workers' rights reforms loom on the horizon, we at Unum are looking forward to seeing the positive impact these changes could bring to individuals, businesses and the broader economy over the next few years. ●

Mark Till is chief executive officer of Unum UK and chairman of Unum Poland

To find out more about supporting employee well-being, read Unum's "Health, Happiness and Productivity" report: unum.co.uk/docs/Health-Happiness-Productivity.pdf

Interview

"Social care is an insurance problem"

Andrew Dilnot on the fate of his proposed reforms and an ageing population

By Megan Kenyon

Shortly after the 2015 general election, the newly appointed social care minister, Alistair Burt made what he has since described as "one of the most difficult phone calls [he] had ever had to make". The call was to Andrew Dilnot, who had led a commission four years previously which looked at how the UK might make its social care provision more equitable.

The Dilnot reforms, as they have since come to be known, included a lifetime cap on care costs and, under the coalition government, had been due for implementation in 2017. Burt's phone call brought news the reforms would be delayed until 2020 at the earliest.

Today, almost ten years on from Burt's "difficult" phone call and nearly 15 years since the commission, the Dilnot reforms have been delayed indefinitely. They were put on ice for the foreseeable future by the Chancellor, Rachel Reeves, at the end of July, shortly after the general election, in a move which Dilnot viscerally told BBC Radio 4's *Today* programme had "failed a generation of families". Reeves blamed a £22bn financial "black hole" left by the previous government. Speaking to *Spotlight* from his office at Nuffield College, Oxford – where he was the warden until his retirement at the end of September – Dilnot said: "At the time, I thought this is a tragedy, and I still think it's a tragedy."

For Dilnot, who has worked tirelessly as an advocate for social care reform since his time at the helm of the commission, successive governments have failed to make good on promises made to some of the most vulnerable people in society by not following through with adequate social care reform. It was not the first time, he said, that the "promise was not to be trusted".

It was in 2010 that the incoming prime minister, David Cameron, invited Dilnot to lead what became the Commission on Funding for Care and Support. Dilnot – alongside the former health minister Norman Warner and former Care Quality Commission chair Jo Williams – set to work. "We spoke to a very wide range of people, both within the sector and outside," Dilnot explained, "and had input from economists, political scientists and philosophers."

Once completed, the commission offered four recommendations: a more generous means test, so that more

people would become eligible for state-funded care; a cap on the lifetime amount a person might spend on social care; the continuation of the disability living allowance and attendance allowance; and a new national threshold for care eligibility, ending local variability between council areas.

The reforms were welcomed across the political spectrum. The government and the opposition, led by then Labour leader Ed Miliband, spoke warmly of Dilnot's recommendations. But progress towards implementation was typically slow. And ultimately disappointing. Dilnot describes the coalition's attempt at reform as a "less generous version of our proposals than we would have liked".

The Care Act 2014 included the implementation of the lifetime cap on care and a readjustment of the means test. Both were due to come into effect in 2017.

That was until Burt's 2015 phone call. Progress since has been rocky. It encompasses Theresa May's "dementia tax" (which Dilnot said "wasn't at all the right way forward") and Boris Johnson's health and social care levy, a 1.25 per cent rise in National Insurance, which became the sole victim of Liz Truss's infamous tax cutting mini-Budget.

But when he first outlined these proposals almost 15 years ago, did Dilnot have any inkling they would prove so difficult to enact? "I could imagine a shorter time line, but I also thought, honestly, when you take something like this, there's probably a one in three chance it will happen," Dilnot said. "[The new Labour government] haven't ruled out coming back to this. That's what I'm working on hardest at the moment."

Dilnot's expertise has not always been in social care. He was previously the director of the Institute for Fiscal Studies (IFS) between 1991 and 2002, and is an economist by trade. "My main area of focus was the tax and social security systems," he told *Spotlight*. "I hadn't done an enormous amount of work on social care when I was at the IFS." He explained he went into the commission with an "open mind".

Now, over a decade on, Dilnot knows more than most about the extent of the crisis in social care. Successive governments have struggled to find a workable solution. Part of this, according to Dilnot, is linked to how we approach and view social care – his background as an economist is clear in this approach. "You and I are both likely to need social care before we die – 80 per cent of us will. But we have no idea how much of it we will need," he said. "Some people will need nothing, some will need a small amount, and a small number of people will need an enormous amount. That's an insurance problem."

Dilnot explained that no private healthcare provider would be willing to insure that far ahead – it is simply too risky. That is why the state must step in. "The state can do this because it is something we can do together. We can change the rules so that the state can provide that risk-pooling," Dilnot explained. This is essentially what Dilnot's reforms aimed to do – to make care more accessible to more people by making state support more generous and available. "By doing nothing, we're condemning those who use the sector, who work in the sector, to continued unbelievable strain."

Andrew Dilnot's proposed reforms were scrapped by Rachel Reeves earlier this year

GERAINT LEWIS/SHUTTERSTOCK

Eighty per cent of us will need social care before we die

Indeed, despite his reforms' rocky history, Dilnot is confident of their eventual success. The rising cost of care and increasing number of people living into old age will make change inevitable. "We talk about the burden of ageing as though it's bad to live longer," Dilnot said. "It's bizarre. The alternative to living longer is being dead, which, on the whole, is not what people would prefer."

With the government currently in a fiscal deadlock, and side-stepping key decisions over social care reform, it's unlikely change will be imminent.

But this parliament still has almost five years left to run. Dilnot remains positive. "I'm not confident that it will happen this year, or next year. But in the end, I'm confident that something with this broad characteristic will happen." ●

Advertorial

No health, no growth

The millions living with musculoskeletal conditions cannot be ignored if the economy is to grow

In association with

Over 20 million people – around a third of the UK population – live with a musculoskeletal (MSK) condition. These conditions encompass a wide range of problems that affect joints, muscles, necks and backs including forms of arthritis. These often lead to severe pain, stiffness, and decreased mobility. Despite the extreme prevalence of MSK conditions and their debilitating effects, access to treatment has fallen victim to wider NHS backlogs: in July there were 342,593 people on MSK community waiting lists in England – this is the largest single condition cohort on the community backlog.

Primarily, for those living with an MSK condition, the lack of sufficient surgical and more personal, localised, community treatment – including effective rehabilitation – is consigning hordes of people to high levels of pain, for far too long. But it is also hampering our social welfare system, industries and economy more widely. Unsurprisingly, being in high levels of pain impacts a person's ability to work. Only 62.4 per cent of people with a musculoskeletal condition are in work, compared to 82.1 per cent of those without one. Such a status quo can affect one's financial stability, leading to borrowing or spending savings, or missing out on potential pension contributions. Furthermore, the impact of MSK conditions is not equal: research shows that those who live in the most deprived fifth of society are more likely to report arthritis or a long-term MSK condition compared to those living in the least deprived fifth.

Both prior to the election and since taking office, two of Labour's key "missions" for government have been to create sustained economic growth and to build an NHS that is fit for the future, unburdened by its record waiting lists. A consensus is growing among economists and health experts alike: you cannot achieve the former without the latter.

"MSK conditions are one of the top two reasons for lost working days for employers, alongside poor mental health; there is a close correlation between the two," explains Rob Yeldham, director of strategy, policy and engagement at the Chartered Society of Physiotherapy (Arthritis and MSK conditions accounted for 23.4 million days lost in work in 2022.) "We know there are significant productivity efficiencies possible

Arthritis and MSK conditions accounted for 23.4 million lost working days in 2022

through supporting more people into work, which totals around a £2bn boost to the economy through reduced benefits payments. That is even before we account for increased tax receipts and reduced spending on health and social care," he added. "We've surveyed people with osteoarthritis, and about three in ten said that their condition impacted their ability to do work," said Tracey Loftis, the head of policy, public affairs and engagement at Versus Arthritis, the UK's largest and leading arthritis charity.

It seems the message – that economic growth isn't possible without a healthy population – is getting through. On 9 July, less than a week after taking office, Wes Streeting, the Health Secretary, set out his stall. The Department for Health and Social Care, he announced, will expand its focus to also boost economic growth. This includes harnessing the life sciences sector and bolstering job opportunities with the health service – but perhaps most notably, the government states: "By cutting waiting times and improving public health, the government will support people with their health and speed up their return to work, while maintaining the good health of those in work." Streeting added: "By cutting waiting lists, we can get Britain back to health and back to work, and by taking bold action on public health we can build the healthy society needed for a healthy economy."

Experts such as Versus Arthritis and the Chartered Society of Physiotherapy, as well as those experiencing MSK conditions, must be involved in the design of interventions and kept at the heart of decision-making. Streeting and Liz Kendall, the Work and Pensions Secretary, will be instrumental in this.

"We spoke to both of them at our stand at Labour Party conference in September, and we were quite encouraged by what we heard," said Yeldham. While Labour's manifesto policies – which included developing better neighbourhood services, including physiotherapy treatment – are hugely encouraging, Yeldham added. A big challenge for the government to fix is the "postcode lottery" of available help to people: "The challenge is to make sure that what is said in Whitehall actually gets translated into action locally," said Loftis. "That requires, the right policies, but it also requires the right funding and the right data to be collected."

Arthritis and other MSK conditions need to be taken seriously by the government if it is to achieve its missions on economic growth and the NHS. Due attention must also be paid to people dealing with "multimorbidities": those suffering from two or more major conditions (such as cancer, respiratory diseases, cardiovascular diseases, dementia and ill mental health), in addition to and including an MSK condition. "A real cross-government, cross-system approach is needed," said Loftis. ●

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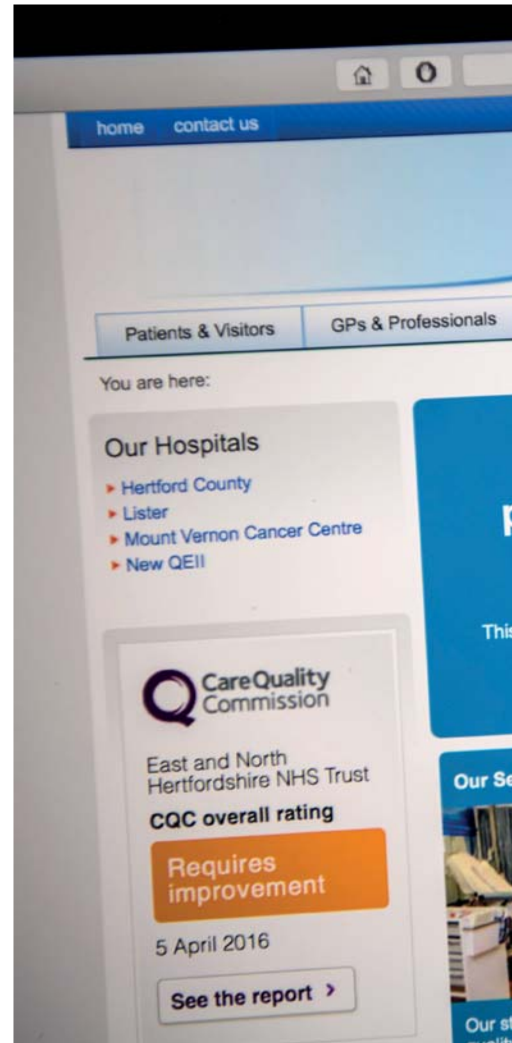
A digital dilemma

For the health service, the rewards of new technology remain elusive

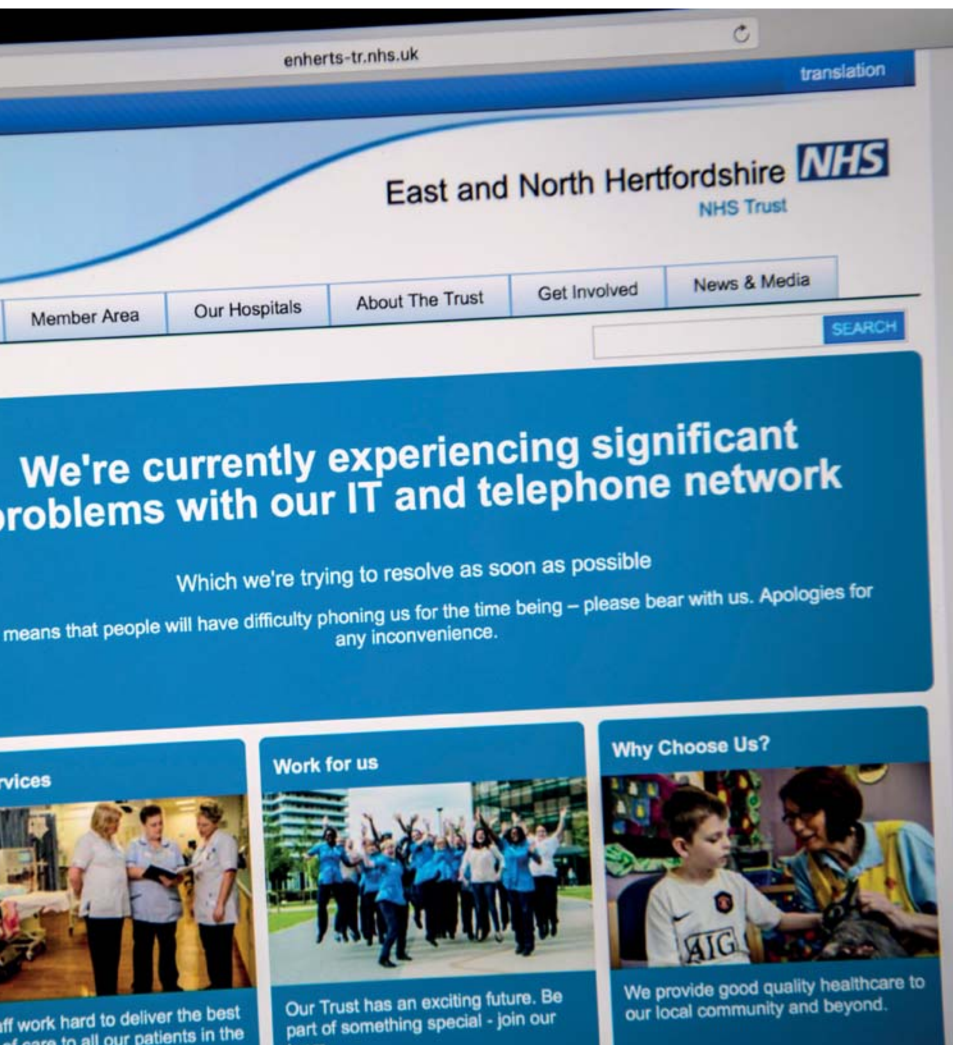
By Sarah Dawood



In June, a doctor at my GP surgery referred me for a blood test. Three months later the form was still gathering dust on my bedside table. In that time, my local hospital was unable to conduct any routine blood tests following a Russian cyberattack on their pathology provider Synnovis, bringing many diagnostic services to a standstill.

This huge ransomware attack had a significant impact on the patient backlog, given seven London hospitals rely on Synnovis. Hospitals were forced to prioritise urgent blood tests only, and even revert to archaic pen and paper to deliver results to patients. What's more, confidential patient data was allegedly published maliciously on the dark web.

A month after this attack, another IT event took down NHS hospitals again – this time, a global Microsoft outage following a faulty cybersecurity update from the third-party provider



Cyberattacks are among the challenges the NHS faces when moving to new technology

CARL COURT/GETTY IMAGES

CrowdStrike, which stopped GP surgeries from being able to access patient records or refer them to hospitals for tests or appointments.

These kinds of incidents severely disrupt access to essential healthcare. It's no secret that the NHS's creaking digital infrastructure is highly susceptible to both planned attacks and major IT malfunctions, causing distress, frustration and poor outcomes for staff and patients. According to a survey conducted by the *British Medical Journal*, roughly three quarters of NHS trusts in England are still reliant on paper patient notes and drug charts, and 4 per cent said they still use paper notes alone. Many NHS trusts are also still using archaic technology such as pagers and fax machines. Meanwhile, roughly half of NHS trusts have an MRI or CT scanner in operation past the recommended lifespan of ten years.

Successive governments have vowed to transform the NHS's out-of-date digital infrastructure with little success, and ambitious targets to make the NHS "paperless" have been missed. A previous attempt to create a centralised patient record system cost the taxpayer nearly £10bn, and was dubbed the "biggest IT failure ever seen".

In his *Independent Investigation of the National Health Service in England*, published last month, Lord Darzi wrote that he was "shocked" by what he found. He called for "a major tilt towards technology to unlock productivity". Inadvertently, perhaps, his language echoed that of Jeremy Hunt who in his last Budget as chancellor pledged £3.4bn towards boosting the health service's productivity, particularly through "harnessing new technology" such as artificial intelligence (AI) to reduce admin and speed up diagnoses. While the new government has yet to commit to a figure of this size, Prime Minister Keir Starmer has committed to a £171m-per-year Fit for the Future fund, which aims to introduce "state-of-the-art" scanners able to detect diseases such as cancer.

Speaking to *Spotlight* prior to the general election Karin Smyth, now a minister for health, said that Labour's approach to NHS digital transformation will be focused on "what it means for patients, what it means for staff and what it means for the system". The Fit for the Future fund is "ring-fenced" for increasing access to scanners to improve diagnosis rates and help bring NHS waiting lists down, she said, but "where places are [already] doing that", then the money will instead be "targeted and focused on other pools of capital to make the system work better".

Healthcare professionals worry that focusing on new technology such as AI is the wrong approach. "All the hype about innovations like AI tools for detecting lung cancer won't matter if we don't get the basics right," says Dr Katharine Halliday, the president of the Royal College of Radiologists. "A sophisticated AI tool is useless if patients miss appointments because their invitations arrive too late; image-analysis AI tools are pointless if computers take 20 minutes to start each morning."

Doctors and nurses routinely complain about inadequate technology making their jobs harder rather than easier. A broad variation in digital proficiency across the country means that interoperability – the ability to send information between different NHS trusts, GP surgeries, hospitals or systems – is lacking.

The BMA estimates that 13.5 million working hours are lost by doctors in England every year due to inadequate IT systems and equipment. Dr Latifa Patel, the BMA's representative body chair, agrees that beyond hardware malfunctions such as computers that constantly freeze or run out of battery, a regular source of frustration is "systems that don't talk to each other".

"[In the NHS] files are often saved as PDF attachments or even printed out and physically moved from one place to another, slowing everything down and increasing the likelihood of human error," she tells *Spotlight*. "For doctors, it results in added stress, frustration and ▸

◂ wasted time that could be spent actually treating patients."

Speaking anonymously to *Spotlight*, one A&E doctor says that the IT set-up has been different in every hospital they have worked in, with some requiring multiple logins for different purposes, such as recording patient notes, ordering prescriptions or referring for scans. In their current hospital, time is wasted trying to find a working computer, calling the IT department because the patient database software has crashed, or struggling to generate blood-sample labels because of faulty printers.

A London-based doctor working in general internal medicine tells *Spotlight* that they also struggle with data collection. Their trust – Barking, Havering and Redbridge University Hospitals – is one of the last in the capital to move away from paper records, and is currently in the process of integrating an electronic patient record (EPR) system. They write all notes by hand. "On a ward round, I have to lug this huge folder around, whilst writing on pieces of paper, and making sure half the things in there don't fall out," they say.

Retrieving important information, such as tests, investigations or medical incidents, is extremely difficult because you can't "search" paper records like electronic ones. "If patients have been there for weeks or months, they accumulate hundreds of pages of notes, which are not easy to look through

5%

of the health department's budget goes towards capital spending which includes IT

13.5m

working hours are lost by doctors in England every year due to inadequate IT systems

£10bn

The cost of a previous attempt to create a centralised patient records system

because of legibility issues amongst other things," they say. An enormous amount of time is taken up doing repetitive work, such as handwriting blood-test bottle labels, or filling out forms to request diagnostic scans: "It's not 'doctoring' or 'decision-making'."

A postcode lottery exists for digitised patient records, with some NHS trusts miles ahead of others. As part of the £3.4bn allocated by the previous government towards NHS digital transformation, £2bn of this was due to be spent on centralising patient records.

The new Chancellor, Rachel Reeves, is due to deliver her first Budget on 30 October, and it will hopefully shed more light on NHS capital funding, which includes upgrading IT systems.

Smyth highlighted the importance of focusing on "the basics" of digital transformation at first. "That might be printers, computers operating on out-of-date software, let alone when we get to use equipment to its full use, and use things like AI for diagnosis."

One of England's most digitally advanced NHS trusts is Oxford University Hospitals. It introduced a comprehensive electronic patient record system more than a decade ago, joining up all patient correspondence, records and test results into the NHS app. This digital transformation has saved the hospital "hundreds of thousands of pounds" a year, says Matt Harris, interim chief digital partnerships officer.

The hospital also uses simple forms of AI to assist doctors – for example, an automated tool is used for hospital bed management, so that doctors and nurses can check for spare beds across different buildings and wards. The hospital is also looking to integrate image recognition technology into specialisms like radiology, and use it to detect lung nodules that could indicate cancer.

Jane Dacre is a rheumatologist, former president of the Royal College of Physicians, and chair of the previous Health and Social Care Committee's expert panel on healthcare policy. Published last year, the panel's report into digital transformation flagged several issues: a lack of interoperability between NHS organisations; geographical disparities in accessing the NHS app or using electronic record systems, for example; and a lack of

Labour has promised reforms to IT procurement

digital literacy and training among patients and staff.

In addition, new equipment is not being used "to its full potential" due to workforce shortages, Dacre says. "It's easier to buy shiny new kit than it is to train people to use it effectively. The resource to buy new kit is different from the resource [needed] to make it work." The NHS also loses out to the private sector due to comparatively poor pay. While the new government reached an agreement with the BMA over a pay deal for junior doctors, wages are not the only stumbling block to recruitment and retention. Hiring specialist digital staff in the NHS is challenging, and leaves it reliant on more expensive third-party suppliers.

And while hospitals that excel in digital transformation might be an exemplar for the latest healthcare innovation, their existence has unfortunately also widened geographic inequalities. The organisations that are best at IT tend to be given more funding than those that need it most, the panel found. In 2016, NHS England created a £100m funding pot specifically for the 26 most digitally advanced trusts, so that they could "drive forward better use of technology in health". A fairer funding approach based on need rather than merit therefore needs to be prioritised.

Given the large discrepancies in digital proficiency between NHS organisations, from hospitals and GP surgeries to acute care, it's obvious there needs to be a centralised overhaul of patient data, too. But Harris believes that trying to create a one-size-fits-all approach is likely to prove unattainable. "To get GPs to use the same system as acute [care], a community hospital or a mental health hospital – unfortunately, they're all quite different."

Instead, he believes there needs to be a "centralised commitment" from third-party tech companies to work together. Due to the competitive nature

Keir Starmer and Wes Streeting on a visit to Bassetlaw Hospital, Nottinghamshire, during the general election campaign, June 2024

CAMERON SMITH/GETTY IMAGES

of procurement, they tend to duplicate effort which is inefficient both for these companies and for the NHS. There is also an argument that the implementation of new technology should be done on a local level, in consultation with staff and patients. "Making decisions centrally without understanding the actual nuances and the working processes at an acute hospital is dangerous," says Harris.

Taking a localised approach can help to tailor technology to the needs of specific populations, and ensure physical and digital NHS services within the same region are joined up, said Labour's Smyth. It can also move more services out of hospital. Virtual wards, for example, aim to give patients hospital-level care at home, with access to tests, treatments, remote monitoring systems and a clinical team.

The Health Secretary, Wes Streeting, believes the private sector has a crucial role to play in delivering essential services to the NHS, and helping to clear the backlog. Labour plans to introduce an NHS innovation and adoption strategy in England, which will reform procurement processes, and create better incentives for companies to invest their new products in the NHS.

But for patients to truly benefit, healthcare staff should be more involved in the process, says the BMA's Patel. There should be more transparency around procurement, and doctors should be given input into how money is spent. "Ultimately, we are the ones that will use these systems, so we must have confidence not only in performance, but also in safety and security. New tech needs to deliver for patients and for staff, and not just boost profits for commercial companies."

Industry professionals argue that to avoid wasting public money on fruitless projects the projected impact of new products and services should be better scrutinised. Companies should have to "test and measure their technologies against reliable data" that shows tangible improvements in patient outcomes and cost savings, says Nick Lansman, CEO at the Health Tech Alliance, a consortium of NHS-procured tech companies. There is a lot of exciting technology on the horizon for the healthcare sector, from virtual wards and wearable devices to the use of robot assistants in surgery and AI in diagnostics. If delivered effectively, they have the capacity to improve patient care, increase staff productivity and working conditions, and save the NHS money. But without robust digital systems in place, their benefits cannot be fully realised.

Only 5 per cent of the Department of Health and Social Care's budget currently goes towards capital spending, and of this only around 10 per cent goes towards IT and software. In her pre-Budget statement on 29 July, the Chancellor made clear the dire state of the country's public finances, and the need to rethink major infrastructure projects, including the New Hospitals Programme, a Boris Johnson-era plan to build 40 new hospitals.

The new government's first Budget, on 30 October, will determine what value it places on NHS digital transformation, and where it will direct its efforts: towards the allure of new technology or towards the mundane but critical task of upgrading the NHS's laggard IT infrastructure. ●

Advertorial

How we can continue to innovate in the care of rare diseases

The UK has a compelling offer in cutting-edge science, but more must be done to realise its potential

By Dr Kylie Bromley

In association with

The way in which we can diagnose and treat rare diseases in the 21st century is one of the remarkable success stories of modern healthcare. Clinical leaders, the patient community, health systems, researchers and the life-sciences industry have worked together in ways which have driven previously unthinkable results. We have been able to classify, research and provide treatments for many rare conditions, often affecting the youngest and most vulnerable in society. For example, in recent years the UK has seen real advances in the health outcomes of those suffering from cystic fibrosis and spinal muscular atrophy.

Yet, although breakthroughs have been made in many areas, we still have so much work to do. Amazingly, 95 per cent of identified rare diseases have no treatments available to those who are affected by them.

As ever, there's an important caveat about the concept of rare diseases. When we use that term, we are talking about a huge group of individuals in the UK, perhaps 3.5 million. When you add the families and communities so often also affected by these conditions, we are talking about many millions more.

There is a clear chance for the UK to take a strong and credible global leadership position in the field of personalised medicines and rare disease. Doing so would benefit patients and their communities. It would also demonstrate to the world that the UK can be the life-sciences hub it aspires to be, supporting the new government's mission to deliver much-needed growth. But to do so, we must connect a complex series of dots.

In the UK, successive governments have driven agendas to delve deeper into the science of human genetics and the genome. The previous government was clear in its aim for the UK to be "the most advanced genomic healthcare system in the world". As one of the consequences of that objective, Genomics England is running the Generation Study, which aims to sequence the genomes of 100,000 newborn babies. This takes advantage of important aspects of our existing research environment and its connections to the NHS. There are many other ambitious partnerships pulling in the same direction, such as Our Future Health. These grand projects are going to be critical when it comes to finding

solutions in rare diseases, where 80 per cent of conditions are genetic in origin.

This ambition is inspiring and plays upon the UK's strengths in science and healthcare. As a global biotech company, we are encouraged to see that the UK is one of the world's leaders in this area. This is a credible story, up to a point.

However, we can also see a developing disconnect across our systems of innovation and healthcare that we must work together to solve.

As we understand the genetic causes of diseases better, medicines can be developed which address the specific patient populations most likely to benefit. This can also avoid exposing patients who are unlikely to benefit to side effects. We believe that this represents progress, as we move further away from the less targeted approach of old.

But these new medicines often come with a significant cost per patient, limited data, and high levels of uncertainty due to the sometimes hard-to-reach nature of the patient population in question. This is particularly the case for first-in-class medicines, which represent scientific breakthroughs, and which may deliver incremental clinical benefits.

It is apparent that the way England assesses these medicines for use on the NHS, via an appraisal by the National Institute for Health and Care Excellence (NICE), is not moving as fast as the science. The evidence is building. Across the UK we lag behind comparable European countries in making these medicines available to patients. Recent figures published by the European Federation of Pharmaceutical Industries and Associations (EFPIA) highlight that those non-oncology orphan medicines receiving reimbursement took 433 days on average to be available on the NHS in England. This compares to 367 days in Scotland and 107 days in Germany.

A 2023 survey of member companies of the Association of the British Pharmaceutical Industry (ABPI) and the BioIndustry Association (BIA) showed that out of 64 medicines granted marketing authorisation since 2018, fewer than half were reimbursed and available to patients in the UK. Eleven out of 18 companies reported that they expect less than 75 per cent of their rare-disease medicines will be launched in the UK over the next five years.

The pattern appears to be that an increasing number of these medicines are being delayed or not getting into the hands of physicians, where they are needed most. So, we have a problem to solve. The UK's end-to-end story does not hold up without this final, most important part of the chain – patients and their communities who are missing out on treatments. Clinicians are losing the experience of working with new innovations. The UK's offer as a life-science powerhouse is critically undermined. We need to think broadly to find a solution that will benefit all the stakeholders. The advent of a new government, with a forthcoming ten-year plan for the NHS and a proposed NHS innovation and adoption strategy, gives all parties the chance to look again. It would be too bold to say that any one group had all the answers. But there are important questions: does it always make sense to rely upon the rigid cost-effectiveness model of NICE when assessing more personalised medicines for rarer diseases? What could we learn from other European countries where these medicines are often made available more quickly? Could we consider other factors in making the decision, such as the innovation of the medicine and the total amount the NHS spends on it?

The UK has a compelling offer in terms of generating cutting-edge science in rare diseases. However, we must be frank about current failings and work together to find a solution, to the benefit of all. Biogen has provided funding support for this activity. ●

BIOGEN

The UK must think broadly to improve the innovation of rare-disease medicines

Advertorial

Kickstarting growth: will complex health issues be ignored?

The government must grasp the opportunity to change our approach to underserved conditions

By Dr Sam Barrell

In association with

On 30 October, the new Labour government will unveil their first budget. Since taking office it has been clear that their top priority is growing the economy. In July, the Department for Health and Social Care (DHSC) even recast itself as an "economic growth department" – to some confusion and furore.

Meanwhile, I am delighted to have started as the new chief executive for LifeArc, a self-funded medical research charity with a focus on turning pioneering science into medical breakthroughs for patients in areas of underserved need. As I begin my role, I can't help but wonder what this new laser-focus on growth means for patients who are traditionally the hardest to help.

Labour have insisted we can't just tax and spend our way to growth, so the question becomes one of how we can maximise the productivity of the people and resources we have already.

Government have rightly identified that one answer is to make people healthier: the fewer people off sick, the more are contributing to the economy. But the quickest way to boost growth through health will likely be in the areas where most people are sick – or, put another way, by focusing on the people suffering from the most common diseases.

A 2024 report by Deloitte found that poor mental health costs UK employers £51bn a year. In a separate report, PwC and the Association of the British Pharmaceutical Industry (ABPI) found that better access to just four classes of medicines could unlock £17.9bn in productivity gains.

Neither area has a straightforward solution. But the huge potential gains threaten to overshadow less prominent, higher-risk or commercially uncertain medical challenges. We focus on these underserved conditions at LifeArc: childhood cancers, respiratory conditions, rare diseases, neurodegenerative conditions like motor neurone disease or emerging viral threats.

Even in the case of antimicrobial resistance (AMR) where the global impact is huge and rising, the challenging commercial reality means we have barely seen any new classes of antibiotic treatments in 50 years. It's not a quick fix. The common denominator is what you might call "market failure": a cocktail of

Improving innovation and care for underserved conditions can help turbocharge economic growth and improve health

complexity, cost and uncertainty which make it less attractive to fund studies, start companies or invest in assets in these areas. As a result, there has been little to no progress.

The big challenge for government as they pursue growth is to avoid mirroring these market failures, and missing opportunities for growth in areas where the market is less interested. If the DHSC focuses too narrowly on big wins it would risk echoing the market, which inevitably leaves some patient populations behind. Thankfully, this is avoidable.

First, the DHSC hasn't given up on its responsibility to serve the public, and they don't need to. Even science for rarer conditions, despite higher risks and costs, generates economic impact. Rare disease research helps alleviate an immense economic burden on the NHS – possibly costing over £23bn per year* – but also, as we see every day at LifeArc, it generates licenses, patents and "spin-out companies" attracting private investment, creating jobs and driving growth.

Second, science is unpredictable. Even small efforts early on or in "niche" areas can lead to unexpected impact across the board. Earlier this year we collaborated on a first-of-its-kind plan for an NHS Trust to hold the market authorisation (or licence) for a gene therapy, so patients can benefit directly. This NHS-life science partnership could pave the way for similar deals across disease areas.

See also clinical trials: it's challenging to run trials for small patient populations, but innovating safely in this area, including with regulation, could speed up patient access to quality treatments in all areas. Keep an eye on the new Centre for Acceleration of Rare Disease Trials, a UK-wide collaboration led out of Newcastle, Birmingham, and Belfast.

Third and finally, we can share the risks of market failures. On AMR, LifeArc is now part of two major collaborations – Pathways to Antimicrobial Clinical Efficacy (PACE) and the Fleming Initiative – which aim to drive pioneering science towards patients, tackle complex challenges through partnership, and make progress where for too long there hasn't been enough.

So, what does growth mean for patients who are traditionally hardest to help? The answer cannot be health versus wealth. LifeArc will keep driving ambitious partnerships to enable pioneering science to create impact for patients. Government must balance their growth focus with the need for innovation in all areas of health. That way, together, we can make life science life changing for everyone. ●

Dr Sam Barrell is chief executive of LifeArc

LIFEARC

Symposium

How should the government tackle health inequalities?

Addressing the issue will be key to fulfilling its health mission

THE NHS IS TAKING ITS RESPONSIBILITY SERIOUSLY

Bola Owolabi
GP and director, inequalities improvement programme, NHS England

The stark reality of health inequalities in England was highlighted once more in Lord Darzi's recent review of the NHS. These are big and complex challenges, which need more than quick fixes.

It is a founding principle of our NHS that no one should be left behind or excluded.

The NHS has identified priority clinical areas for adults and children, where we need to accelerate improvement among the most deprived 20 per cent of the population plus others who experience lower than average access, experience or outcomes.

There are brilliant examples of the NHS developing local innovations to promote more equitable health up and down the country; a mobile dental clinic in Suffolk managed by the local council to assess, treat and give advice to vulnerable children and young people, including those with learning disabilities or who live in care.

Secondly, asthma-friendly schools and youth clubs in Birmingham that provide all children with asthma with a personalised plan, building understanding of the condition among teachers, parents and fellow pupils while playing their part improving local air quality.

Third, a social enterprise improving GP registration among people living in temporary accommodation across Bristol, North Somerset and South Gloucestershire, also offering vaccinations, blood tests and information about wider health services.

Crucially, each of these shows the NHS working across traditional boundaries – hand in hand with local councils, charities, community groups or other strategic partners.

For the NHS to help address longstanding health inequalities, we must continue to make this a collective and collaborative mission.

Only by doing this can we realise our vision – exceptional quality healthcare for all, underpinned by equitable access, excellent experience and optimal outcomes.

WE CAN'T CLOSE INEQUALITIES WITH AUSTERITY

Sir Michael Marmot and Jessica Allen
Director, and deputy director, Institute of Health Equity and University College London

The poor health of the poor is shocking. Men living in the vicinity of Grenfell Tower had a life expectancy 22 years shorter than those living in the rich part of the Royal Borough of Kensington and Chelsea. Let us take a moment to think about the health of people living in the least deprived areas. Health follows a social gradient – the greater the deprivation, the higher the mortality rate. If everyone below the top 10 per cent had the low mortality rates of the best off over the decade from 2010, there would have been 1 million fewer deaths. Excess linked to deprivation amounted to 148,000 more than would have been expected in the previous decade – 148,000 deprivation-related deaths, plausibly linked to austerity.

This scale of excess mortality cannot be explained by the crisis in the NHS, important as that is, but is closely linked to the social determinants of health – all affected by austerity. To give one example, over the decade from 2010, central government support to local government was reduced by 59 per cent, in regressive fashion: the more deprived the area, the greater the reduction.

That would suggest that to reduce health inequalities, austerity should be reversed. It should. But, in the meantime, there is much that can be done. In 2012, Coventry declared itself a Marmot City. Our 2010 Marmot Review had six domains of recommendations: give every child the best start in life; education; employment and working conditions; minimum income for healthy living; healthy and sustainable places including housing; and taking a social determinants approach to prevention. Coventry took these as the basis of cross-sector action involving the city government, health and care, the voluntary community and other public sector organisations. By the end of this year, there will be 50 Marmot places.

We have the evidence. We have the examples of good practice despite the paucity of funds. Now national government must come behind these hopeful, inspiring initiatives.

GIVE LOCAL GOVERNMENT RESOURCES TO INTERVENE

Greg Fell
Director of public health, Sheffield Council

Improving the nation's health will require much more than NHS reform. Health inequalities are driven by a vast array of factors, including housing, education, employment, product consumption and the environment. In fact, only 10-20 per cent of our health is determined by access to traditional health services. Health inequalities are also often intergenerational, meaning any solution needs to break that cycle by considering the impact these factors have at all stages of life.

With multiple factors involved, there needs to be acknowledgement that it will take multiple solutions. We need long-term plans to create healthier environments that give everyone access to all the things needed for good health.

For example, addressing child poverty is crucial. The government have already made a start, but this work must continue at pace, with input from across both government and the political spectrum. Meanwhile, nearly 89 per cent of deaths in England are attributable to non-communicable disease, largely avoidable conditions often caused by health-harming products like tobacco, alcohol, and unhealthy food and drink, which disproportionately affect people living in the most deprived areas.

The tobacco and vapes legislation would save thousands of lives and do more to reduce health inequalities than any other single piece of legislation could. The government should then apply the same principles to other products like alcohol and unhealthy food and drink so that any products harmful to us or the planet are restricted, regulated, and their manufacturers excluded from policymaking.

The government don't need to reinvent the wheel. There are plenty of evidence-based solutions which could be introduced quickly. They must invest in public health at a local, regional and national level so that the measures we know work can be implemented on the ground and we can begin to reduce health inequalities both now and for the future.

"There are plenty of evidence-based solutions that could be introduced quickly"

PRIMARY AND COMMUNITY CARE WILL BE KEY

Thea Stein
Chief executive, Nuffield Trust

Health inequalities have been a long time in the making – everything we know about what will improve them (let alone eradicate them) says it will take focus and commitment across the whole of government over a significant number of years. It is certainly not just a job for the health services.

Key to tackling health inequalities is the proper resourcing of local authorities. Many are in a critical condition, with budgets that don't stretch to do all they want or should do. It is local authorities that should be able to make real inroads in tackling inequalities and who hold the public health budget for their area, which by 2022/23 had been slashed by 24 per cent in real terms per head. With sufficient long-term funding and powers to tackle local issues, real progress could be made on clean air and green space, good education, subsidised transport and gyms, safe and warm housing, as well as proper levels of funding for social care for children and adults.

And the government needs to come good on the promise to prioritise primary and community care. One sensible action could be to introduce a combined primary care and community services investment guarantee, boosting the proportion of NHS spend in this area by 1 per cent a year and monitoring the impact of it relentlessly. We need to strengthen general practice and community services to prevent ill health, and improve early diagnosis of conditions like cancer, heart disease and diabetes. The evidence is there. The unswerving political will has to follow.

BOOSTING HEALTH CAN PROP UP OUR ECONOMY

Matthew Taylor
Chief executive, NHS Confederation

Britain has a sickness problem. Since 2020, economic inactivity in the UK has risen by 900,000, and now stands at 2.8 million people with 85 per cent of this increase down to those who are not working due to long-term sickness.

Until the start of covid pandemic, economic inactivity rates in this country, whilst high, were in step with similar countries, yet since then we've become an outlier. On average EU countries have seen economic inactivity fall by more than 2 per cent; the UK's has risen by more than 1 per cent.

It does not take a mathematician to work out this is impacting the economy. Yet if the trend could be reversed, our estimates suggest a potential £35bn dividend to taxpayers over five years and that's just from halving the post-Covid inactivity increase.

For the NHS this could reap multiple benefits. If targeted preventative health interventions help people find or stay in work, they also shore up the case to invest in health services. And as people of working age on average become even less well when they are not in employment, helping people with health conditions to access jobs could also reduce further demand on services.

We need to concentrate resources on the conditions that seem to be the main reason for inactivity, namely mental health in children and young people, and musculo-skeletal conditions, and the interplay between mental and physical health.

The opportunities presented by tackling economic inactivity are huge. We cannot take the gamble of doing nothing.

LEARN THE LESSONS OF NEW LABOUR'S HEALTH SUCCESS

Dr Jennifer Dixon
Chief executive,
Health Foundation

Wes Streeting should implement a health inequalities strategy as part of the government's health mission. He could use the previous New Labour government's approach by setting targets. The existing pledge – to halve the gap in healthy life expectancy between regions - is good. He could look at similar for infant mortality and the working age population that are economically inactive due to ill health. The targets could be hardwired into public service agreements as before or with another accountability mechanism, and be transparently (ideally independently) reported to Parliament. Overall strategy must be cross-government, with short medium and longer term goals.

The New Labour approach was successful, with some progress only measurable and apparent after a decade. Crucially there was investment in a wide range of social programmes such as Sure Start, local government and the NHS, all aided by robust background growth in the economy. Autonomy was given to local authorities to design targeted interventions most relevant locally.

There are quicker wins to improve the health of the population without needing much extra cash. A bill curbing tobacco and vapes is already on the cards. The Labour government should confidently dismiss arguments about killjoy nanny statism by arguing it is protecting the public from food and drink pollutants. Drug abuse is wreaking havoc with health in the most deprived areas – implementing the recommendations from the Black Review should be a priority. ●

The view from elsewhere

Dr Nick Watts: "The net zero target was designed to be hard"

By Megan Kenyon

The founding chief sustainability officer of the NHS on a 50:50 chance of hitting the service's 2045 decarbonisation goal

Why does the NHS rarely feature in discussions about net zero?
Clinicians have been slow to this fight. Though, as the NHS is showing, once healthcare professionals show up, they can move mountains. The NHS is running well ahead of its commitments under the Climate Change Act. Healthcare is about 5.5 per cent of emissions in the UK. That's bigger than shipping and aviation. It's not a small piece of what the country does.

Are you confident the NHS will achieve its 2045 net zero target?
The NHS ran its big net zero strategy between 2019 and 2020 to really understand, deep down, where all the emissions were. 2045 was selected, frankly, to be right on the cusp of what we thought was feasible but ambitious. I often get asked, can you hit it, and the answer is often 50:50. The target was designed to be hard.

The costs associated with decarbonisation, for the most part, are pretty minimal for a few of our fixed assets. There's a question of where do you treat your patient? Are you siting them correctly? Do they really need to come in for the fifth time to an appointment in the hospital? I view this challenge almost entirely as a change management process.

The cost of intervention is low, but the cost savings are high. You want to go after some things that could bring serious benefit to the health system itself like energy efficiency or on-site renewable generation. In healthcare we don't have any silver bullets. We've learned over the past five years that this challenge is primarily not a financial one. The return on investment is actually pretty excellent for a lot of the things that we want to do.

How do you measure success?
You've got three metrics you should be chasing. First is carbon. You know it's working, because there is a team that runs a monitoring and reporting system that checks and reports to the sustainability board regularly.

The next thing is can you demonstrate that this is good value for taxpayer's money? Can you take the money spent and reinvest it back into patient care? The third metric is are you getting serious buy-in from your most important asset, the 1.4 million staff across the country? We would monitor and run public opinion polling every now and then – 92 per cent of health professionals want to work in an NHS that is living up to their own values.

How do you make sure the patients' experience isn't harmed in the process?
What doctor do you honestly think would pick carbon over a patient? But you do have to be really thoughtful about it. You have to make sure that every time you're asking yourself, "Is there anything we're doing that could harm patient care?"

If the answer is maybe, then you can't do it. More often than not, we find our interventions end up improving patient care. I would flip it and ask: how do we use this as an intervention? We're going to revolutionise the NHS. We're going to decarbonise the entire health system in a way that improves health and saves money.

You were the first person to occupy this role. What kind of difference can it make?
You need someone who is senior enough in an organisation of that size to be visible, to be proud, loud, and angry. You need someone who cares deeply about this, day after day. It's a pretty specialist thing and the job is really difficult. But without a central team, it's not possible.

I have seen attempts in other countries where healthcare organisations try and say, our chief nurse or chief medical officer is doing sustainability work part time. I've yet to see that be properly successful, frankly, because they've got another very important and serious job as well. ●

Nick Watts is the director of the Centre for Sustainable Medicine at the University of Singapore

MARTA SIGNORI

Advertorial

Nutrition must be central to Labour's health mission

Ensuring equitable access to healthy food and nutrition could relieve strain on the NHS and improve growth

By Richard Hall

In association with

Danone has come a long way since I joined the company over 30 years ago. We've always had a rich history in health – our founder originally sold yoghurts with ferments in pharmacies in Spain to address malnutrition in children. But over the years, as we grew as a company, our multinational portfolio diversified into one that is quite unrecognisable compared to where we are today.

We've moved from selling frozen pizzas, biscuits, and sauces, back to prioritising healthy products – like yoghurts, waters, and plant-based food and drink. This has taken decades of time, energy, and investment. In 1972, Danone's then global CEO Antoine Riboud declared that a company's responsibility does not end at the factory gate. We should be doing more for the communities we serve – for us, that means products that lead to healthier diets and better nutrition for the nation.

Because better health through better nutrition means longer, healthier lives. Yet for too long, nutrition has been a blind spot for us as a nation. We simply don't take it seriously enough, and that has to change.

If the government wants to make the NHS more resilient, it needs to reduce the number of people who are falling ill to begin with. That has to involve tackling obesity and malnutrition as part of a robust, nutrition-focused preventative healthcare model, so more people can stay healthy and in work. With workplace sickness costing the UK economy over £100bn in 2023 it is clear we will not grow the economy until everyone has the chance to lead a healthy life. There will need to be more focus on the vital role nutrition plays in preventing ill-health in the government's 10-year plan for the NHS.

At Danone, our interest in health and nutrition goes beyond the food and drink brands that you might see on supermarket shelves. Our Nutricia brand produces foods for people with specific nutritional needs and for special medical purposes, helping to ensure people can access the nutrients they need if they are unable to do so through food alone. This could include someone who is undergoing cancer treatment, someone who recently had a stroke, or someone who has disease-related malnutrition.

Our nurses also work directly within the community, supporting patients

to manage enteral feeding at home safely and independently. Whether in hospital or elsewhere, it's clear to see that nutrition plays an essential and valuable role in improving people's quality of life. Now, the government must acknowledge that value and build policies that properly support good nutrition for everybody.

Malnutrition and obesity – two sides of the same coin

Poor nutrition can lead to conditions like obesity and malnutrition, which are both on the rise. In 2022-23, 64 per cent of adults aged 18 years and over in England were estimated to be overweight or living with obesity. Whereas 2.9 million people in England have disease-related malnutrition. Naturally, the health repercussions of both conditions place increasing pressure on our already strained NHS.

Research shows that obesity-related ill-health costs the NHS £6.5bn every year, while malnutrition costs health and social services £22.6bn. Both are costing a fortune and yet both are preventable. Maintaining a healthy diet is essential at every stage of life. Poor diet is one of the biggest risk factors for preventable ill-health in the UK. As we grow older, the risk of becoming overweight or obese increases – and can lead to serious health consequences like diabetes or cardiovascular disease.

On the flip side, there are also the risks of undernutrition – particularly for people who are older or who are managing diseases or long-term health conditions. Undernutrition can lead to illness, physical decline, deterioration in mental health, and malnutrition. Yet many people don't have a good understanding of the nutrients they need in their diets to keep them healthy. Nor the fact that you can be both obese and undernourished.

Malnutrition can be difficult to diagnose. It can be a consequence of diseases or long-term health conditions, as well as social and economic factors. Nearly half a million people who are admitted to hospital each year in England have disease-related malnutrition, yet only 2 per cent receive a diagnosis. Earlier diagnosis and better nutritional support for patients can help reduce hospital stays, support recovery, and prevent costly re-admissions. Our research estimates that the additional medical costs of a person with malnutrition is more than three times that of a person without malnutrition. If we don't tackle this issue, disease related malnutrition is projected to cost an extra £4bn by 2035.

Clearly, the government has a key role to play when it comes to nutrition. We need increased screening for those at risk of malnutrition and better nutritional management across all areas of healthcare, and, in general, a greater focus on promoting healthier diets.

DANONE

Danone's Nutricia nursing team provide essential support for patients at home

Industry must play a positive role

The food and drink industry also has an important role to play in helping this shift. As a nation, the UK consumes significant amounts of unhealthy food, including foods that are high in fat, sugar, and salt (HFSS), which are known to have adverse effects on health.

With so much information out there, people need to feel confident in the choices they're making. Last year, Danone UK & Ireland launched – and are upholding – our own sector-leading health commitments. This includes that at least 90 per cent of our portfolio of products by sales volume will not be HFSS, and we'll never produce a product for children that is HFSS.

But we want to see greater transparency across the whole industry. Agreement on what constitutes "healthy food" is essential before we can implement mandatory reporting for food and drink businesses. Then we are likely to see more innovation, and ultimately healthier products on shelves. We want the healthy choice to be the easy choice. But we can't do it alone. And it takes time, research, and investment for companies to alter their products to reduce ingredients like sugar while also maintaining good taste. We're proof it can be done, but we need the government to help drive this type of innovation – and incentivise others to do it.

A circular health system

If we think about it circularly, better nutrition will lead to better health and a more resilient NHS. It seems so simple, yet concrete tactics around prevention are lacking and we're simply not where we need to be.

It's no secret that the new government has a big job on their hands, but the impact of poor nutrition has been illuminated time and again by data from across the country. It should not ignore it. It can make real inroads by refocusing on nutrition to improve health outcomes. It can be done, but the time to do it is now. ●

Richard Hall is vice president, general secretary of Danone UK and Ireland

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