**The NHS and an Ageing Population**

The founding principles of the NHS, established in 1948, were three-fold: that it meet the needs of everyone; that it be based on clinical need, not ability to play; and that it be free at the point of delivery. These founding principles remain at the heart of the service, complemented by more recent commitments to greater accountability, improved standards, best value for taxpayers, a patient-focus, and working across organizational boundaries.[[1]](#endnote-1) But demography, epidemiology, technology and service delivery have changed beyond recognition during the past 70 years. When the NHS was established, 48% of the population died before the age of 65 – a figure that is now only 14%.[[2]](#endnote-2) Success in public health and the development of modern medicine (including pharma and technology) result in a population that is living longer but set to experience greater levels of co-morbidity, disability, and frailty. This review identifies a number of challenges facing the NHS as a result of population ageing and the emerging policy and delivery responses.

**Background**

The NHS**[[3]](#endnote-3)** has a system of primary health care with a key role for General Practitioners (GPs) as a first point of contact and gatekeeper to secondary care.[[4]](#endnote-4) These GPs are increasingly found in larger multidisciplinary teams that include practice nurses (with a focus on prevention, monitoring and management of chronic diseases), nurse practitioners (more advanced practitioners with some prescribing rights), and community nurses and health visitors who are based in the practice or linked to a group or GP practice.[[5]](#endnote-5) Patients do not make co-payments for these consultations and services. Policy over the last 20 years has seen a major transfer of responsibility for chronic disease to General Practice (a move supported by changes to the GP contract in 2004).[[6]](#endnote-6) Under the 2012 Health and Social Care Act, GPs are involved in both healthcare provision and, within local Clinical Commissioning Groups, the purchasing of services for the local patient population.[[7]](#endnote-7)

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**NHS Structure 2016 (England)[[8]](#endnote-8)**

***Bridging the gap between health and social care***

The UK has a longstanding distinction between health and social care and this boundary – and associated cost shunting – is a problem for delivering integrated services with patient needs at the centre.

NHS healthcare (funded centrally) relates to the treatment, control or prevention of a disease, illness, injury or disability, and care or aftercare. Social care focuses on providing assistance with activities of daily living, maintaining independence, and social interaction.

Local Authorities have a duty or power to provide social care services, including social work services; advice; support; practical assistance in the home; assistance with equipment and home adaptations; befriending; provision of meals; opportunities for social and recreational activities outside the home; and assistance in finding appropriate accommodation (e.g. a care home or supported accommodation).[[9]](#endnote-9)

Around 98.8% of revenue for healthcare services is funded by national tax revenues and charges are a relatively small part of the revenue (1.2%).[[10]](#endnote-10) The Figure below shows how the money flows in the new NHS.[[11]](#endnote-11)

Health expenditure has grown faster than national income due to new technology (both pharma and developments that allow better diagnosis, treatment and aftercare); increased consumer expectations and knowledge; and population ageing (rise in life expectancy and increasing multiple chronic diseases).

In 2014/15 public spending on healthcare was 7.3% of GDP – a rise from 5.2% in 1994/5.[[12]](#endnote-12) Whilst NHS funding continues to grow, it is slowing considerably compared to historical trends. Between 2005/6 to 2015/16 the NHS budget rose from £91 billion to £117.2 billion in real terms with the rate of growth high in the first part of the period. Despite such growth a large deficit exists for the NHS budget (£2.5b by 2015/16).

Analysis suggests that over two-fifths of national health spending in the UK is for people over the age of 65. An 85-year-old man is estimated to cost the NHS about seven times more on average than a man in his late 30s. People aged over 85 cost the NHS an average of £7,000 a year compared with the average on health services across all age groups of £2,069.[[13]](#endnote-13) Those aged over 65 made up 41% of hospital admissions,[[14]](#endnote-14) and the average length of stay for emergency admissions in hospital increases with age. There was an 18% increase in emergency admissions of older people 2010/11 to 2014/15 (compared with a 12% increase for whole population).[[15]](#endnote-15) Falls are the largest cause of emergency admissions for older people and cost the NHS around £600 million annually.

Long-term trends of falling fertility and mortality give rise to population ageing. There are 11.6 million people aged over 65 in the UK and 1.5 million of these are aged over 85.[[16]](#endnote-16) By 2040 nearly one-quarter of the UK population will be over 65 and the number aged over 85 will double in the next 20 years to 3.4 million.[[17]](#endnote-17)

Longevity must be accompanied by improvements in healthy life expectancy. UK life expectancy estimates at age of 65 are 85.9 for women and 83.4 for men.[[18]](#endnote-18) *Healthy life expectancy* of people in England is 64 for women and 63.4 for men.[[19]](#endnote-19) In the UK 21% of men and 30% of women aged over 65 needed help with at least one Activity of Daily Living (ADL), and 22% of men and 33% of women needed help with at least one Instrumental Activity of Daily Living.[[20]](#endnote-20)[[21]](#endnote-21) About 40% of all people aged over 65 have a limiting longstanding illness.[[22]](#endnote-22)

These is great diversity *within* the ageing population by socio-economic position, ethnicity, gender and locality.[[23]](#endnote-23) Those who live in the most deprived areas of England for example have nearly two more years of ‘not good health’ after 65 than do those in the least deprived areas.[[24]](#endnote-24)

**Co-morbidities: prevention and co-ordination**

NHS hospital medical specialties were traditionally based around single organ diseases whereas patients are now experiencing multiple and complex conditions or become frail.[[25]](#endnote-25) Frailty is where multiple body systems gradually lose their in-built reserves, and affects around 10 per cent of those aged over 65, and between 25 and 50 per cent for those aged over 85. The challenge is coordinating services around an individual’s needs and prioritising prevention and greater support for independence.[[26]](#endnote-26)[[27]](#endnote-27) The more conditions someone has, and the more limitation on their activities of daily living, the more likely they are to need integrated health and social care. Older people receive the majority of their personal care from family and other unpaid carers and so informal services will remain a crucial part of the overall response. There is a need for more evidence on what works around services for patients with multi-morbidity and for training practitioners to provide support to people with these complex conditions.[[28]](#endnote-28)

One in four older people have symptoms of depression that require treatment. However, less that one in six older people with depression discuss their symptoms with their GP – and of these only half receive adequate treatments.[[29]](#endnote-29) Other evidence suggests:

* For every 1,000 people over the age of 65, 250 will have a mental illness, 135 will have depression, of which 115 will have no treatment.
* 85% of older people with depression receive no help from the NHS, and older people are a fifth as likely as younger age groups to have access to talking therapies but six times as likely to be on medication.
* While 50% of younger people with depression are referred to mental health services, only 6% of older people are.[[30]](#endnote-30)

Commentators highlight befriending initiatives, social prescribing and group activities can reduce loneliness and symptoms of depression.[[31]](#endnote-31)

Over 400,000 people in England have been diagnosed with dementia. Figures show that 0.77% of people registered with a GP practice are diagnosed with dementia (1 person in 130). Dementia is estimated to cost the UK economy over £26 billion a year, with 39% due to social care and 44% due to unpaid care. Dementia patients often have longer hospital stays than other inpatients, and are less likely to return home after a hospital stay. By 2040, predicted costs are expected to treble.[[32]](#endnote-32) It is estimated that 40% of people aged over 85 will develop dementia and be in need of long-term care.[[33]](#endnote-33)[[34]](#endnote-34)

**Discharge from hospital care**

An estimated one-third of older patients initially admitted to hospital as an emergency no longer should be in a hospital bed.[[35]](#endnote-35) The National Audit Office (NAO) notes that 62% of hospital bed days were occupied by patients aged over 65 in 2014/15.[[36]](#endnote-36) Approximately 2.7 million hospital beds were occupied by older patients no longer in need of acute treatment – at an estimated cost of £820million to the NHS. Increasingly, older patients are experiencing delays in being discharged from hospital and such delays are bad for their health and increase the level of care they may need after leaving hospital. Longer stays in hospital can increase the risk of adverse events such as falls, healthcare acquired infections (urinary tract infections, pneumonia) and reduced mobility through muscle loss.[[37]](#endnote-37)

In an NAO study 54% of hospitals in their survey reported that discharge planning is not started soon enough to minimize delays for older patients.[[38]](#endnote-38) Waiting for a home care package was the leading cause of delays; delays because of nursing home placement and residential care placements have also risen sharply. The Public Accounts Committee identified an ‘**unacceptable variation in local performance on discharging older patients’.**[[39]](#endnote-39)For example, the number of officially recorded delayed transfers of care in 2015/16 ranged from 10 days in Northumbria to nearly 18,000 days in Lincolnshire.[[40]](#endnote-40) Improving discharge involves a focus on treatments out of hospital, including co-ordination and partnership at the system level. The **fragile adult social care provider market creates problems in discharging older patients from hospital.**[[41]](#endnote-41)Local Authorities are experiencing austerity and face pressure to reduce fees they pay for social care homes and homecare which in turn puts pressure on care providers. In 2005/06 spending from Local Authority funds on social care for older people organized by local authorities was £8.08 billion. Spending remained relatively constant reaching £8.12billion in 2009/10 before entering a period of sharp decline, reaching £6.31 billion in real terms in 2015/16. The introduction of the national living wage has added further to this pressure given such services are highly labour intensive.

There is a need for better discharge planning – including 7 day discharge. The role of early supported discharge teams offering rehabilitation, equipment, personal care, medical review or nursing interventions, time-limited but tailored to an individual have been shown as effective (e.g. in reducing readmissions and improving outcomes for stroke patient admissions).[[42]](#endnote-42) Intermediate Services help patients avoid hospital admission and allow earlier discharge home – also delaying admission to residential care. Intermediate services work across a range of settings: crisis, re-ablement, home-based and bed-bound.

Innovations in new medical and information technology create new health care tasks, including wider roles for patients and opportunities for more care to be delivered outside of the hospital seting. For example, the use of portable monitors for patients who are at risk of stroke and on oral anticoalulation and monitoring vital signs, and patients can self test and adjust levels rather than spending many hours attending outpatient clinics for monitoring.[[43]](#endnote-43)

**Workforce**

One of the biggest challenges for the current health workforce is that it was trained to work within a model based around single episodes of treatment. However it now must deal with co-morbidities, mental and physical needs, and ensure integrated care.[[44]](#endnote-44) There are staff shortages in medicine, nursing and social care settings. Hospitals face an imbalance across specialties with shortages within emergency, geriatric and psychological services: 14.1% of Geriatric medicine training posts trainee opportunities were unfilled in May 2013.[[45]](#endnote-45) There is an under-supply of GPs and concerns about the growing primary care workload. Within GPs training there is no compulsory geriatric component. The Royal College of General Practitioners has recommended that GP training be extended so that they are better prepared to care for ageing populations.[[46]](#endnote-46) Workforce is a problem for social care with care and residential/nursing homes facing significant difficulties with the recruitment and retention of home care workers and nurses in nursing homes. The UK decision to exit the European Union and ongoing financial squeeze has fueled concerns within the NHS and social care about the difficulties of recruiting and retaining a range of staff.

**The NHS moving forwards**

The NHS continues to receive widespread public support. The task facing politicians and professionals however is to ensure the NHS undergoes a “complete transformation”[[47]](#endnote-47) to become a 21st century integrated national health and social care service. This service would acknowledge the impact of ageing, including more complex consultant work in the GP surgery, and provide a joined-up service based around community and home. There is no silver bullet for the challenges an ageing population presents for the NHS. The solution will require top-down resource allocation and some national policy dictates but must also reflect the reality of decentralized NHS delivery, and the range of stakeholders. Indeed, better health outcomes are reliant in part on attitudinal and behavioral shifts within the population itself.

***Funding healthcare***

According to projections from the Office for Budget Responsibility, the NHS’s budget will need to increase from £140bn in 2020/21 to £228bn by 2066/67 in order to keep pace with the rising demand for healthcare. This would equate to the budget rising by an average of 2% each year – much more than the 1% annual rises of the NHS post-2010. This would see an increase in the proportion of GDP spent on health from 6.9% expected in 2020/21 to 12.6% by 2066/67.[[48]](#endnote-48) It is a moot point about whether this will entail tax increases and co-payments to allow for more spending, or whether the NHS may no longer offer the same range and quality of services.

***Planning and partnerships***

The NHS and local councils have come together in 44 areas covering England to develop proposals and make improvements to health and care known as Sustainability and Transformation Plans (STPs) taking a 5-year forward view. STPs are place-based approaches that outline practical ways for the local NHS to improve services. The NHS must turn these STPs into delivery partnerships focused on implementing the specific proposals with a significant focus on how the local NHS can best respond to an ageing population.[[49]](#endnote-49)

***Social care services and wider ageing-friendly society***

Solutions are not confined to healthcare: supporting family and unpaid carers is pivotal. In 2014, the NHS published its *Commitment to Carers* to give them the recognition and support they need to provide care for their family and friends.[[50]](#endnote-50) Investing in social care services, and joining up policy responses – including transport, housing and work environments – all contribute to addressing the challenges that exist now and into the future. Health Foundation analysis suggests that the funding gap for adult social care is at least £2bn in 2017/18.[[51]](#endnote-51) This will require a social care settlement that is accepted as equitable and enduring – something that currently looks far from achievable given the political differences. Within the STPs there is the expectation that local areas will show ‘significant and measureable progress’ in health and social care service integration.

***National priorities around disease and long term conditions***

The Government will continue to identify priority diseases and conditions and develop overarching strategies to ensure they are tackled. The Government’s first National Dementia Strategy was published in 2009 and the Prime Minister Launched *Dementia 2012: A national challenge* and the *Prime Minister’s Challenge on Dementia 2020*.[[52]](#endnote-52) Key routes to better dementia services include better public awareness and understanding of risk factors of developing dementia; quicker access to dementia diagnosis; better standards of care; NHS staff receiving training on dementia appropriate to their role; and all hospitals and care homes to become dementia friendly health and care settings.

***Training***

In 2014 the Government made a commitment to train and retain an extra 5,000 GPs, including 10-point plan (working closely with the British Medical Association and Royal College of General Practitioners) on how to achieve this. ‘Golden hellos’ for trainees who are willing to work in areas with poor recruitment have been introduced, and there is a review of culture within medical schools to ensure prospective new GPs are not being put off. Analysis of workforce data however suggests that without significant improvement just 2,100 new GPs will be delivered by 2020.

***Care at home and new models of care***

Intermediate care and re-ablement services are a key part of Government attempt to provide health and care within community settings. The £5.4bn *Better Care Fund* seeks to support integrated planning, commissioning and delivery.[[53]](#endnote-53) Under STPs the NHS is to play a role in reducing Delayed Transfers of Care out of acute settings, including developing new incentives.

Ensuring the voices and experiences of service users is at the heart of the NHS, requiring continuous attention to patient experience. For example, the *Family and Friends Test*, a feedback tool asks people if they would recommend the services they have used and offers a range of responses.

***Self-care and prevention***

There is increased expectation that older people take greater responsibility for their health within prevention and self-care initiatives. A number of guides and initiatives support such aspirations. For example, the *NHS Guide to Healthy Ageing[[54]](#endnote-54)* seeks to help people maintain health and fitness, particularly targeting those aged above 70 and contains self-care advice including how to prevent falls and prepare for winter.

***Better End of Life Care Choices***

The Parliamentary Health Committee reports that 80% of the 500,000 people who die each year in England and Wales are aged over 65 and one-third are over 85. Around half of deaths occur in NHS hospitals, with around 21% occurring at home. However about two-thirds of patients would prefer to die at home.[[55]](#endnote-55) Increased patient choice around End of Life Care (as well as other sorts of care) is a key policy agenda.

***Piloting and experimenting with local programmes***

There has been a longstanding encouragement for piloting local initiatives to gather evidence of what works most effectively at the local level. National funding was distributed to a number of local Partnerships for Older People’s Projects (2006-2009), many focusing on prevention initiatives but also initiatives such as lunch clubs. These included a number of interventions aimed at changing behavior of older people (rather than relying on distribution of information), and also the role of peer mentoring.[[56]](#endnote-56) The Partnership for Older People Evaluation found that overall there was improved quality of life and considerable savings, with practical and low-level support offering a major contribution towards wellbeing.[[57]](#endnote-57) Such evidence will have implications for commissioning practices and the development of initiatives – including those delivered in partnership with voluntary sector, older people and their families.

In short, addressing the implications of ageing for the NHS involves a number of interrelated issues – spending levels, responsibility for health, the organization and delivery of health care including purchasing models, treatment roles and related decision making. Taken as a whole these exemplify the need for a holistic study of health systems and the debates will traverse the disciplines of epidemiology; health economics, health policy ethics; health politics health; health management; and health policy.

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