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Health Systems in Action

United Kingdom



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United Kingdom

Authors:

Mark Dayan, Stephanie Kumpunen, Sarah Reed
and Erica Richardson

Editorial Team

Editorial Board: Natasha Azzopardi Muscat, Josep Figueras, Hans Kluge and David Novillo Ortiz.

Editorial team (alphabetically by team):

- Jonathan Cylus, Marina Karanikolos, Suszy Lessof, Anna Maresso, Bernd Rechel and Ewout van Ginneken, European Observatory on Health Systems and Policies.
- Keyrellous Adib, David Novillo Ortiz, Graham John Willis and Tomas Zapata, Division of Country Health Policies and Systems, WHO Regional Office for Europe.

Series coordinators: Bernd Rechel and Suszy Lessof, European Observatory on Health Systems and Policies.

Series editor: Bernd Rechel, European Observatory on Health Systems and Policies.

Health financing analysis (in alphabetical order): Jonathan Cylus, Marcos Gallardo Martinez, Triin Habicht and Sarah Thomson, WHO Barcelona Office for Health Systems Financing, WHO Regional Office for Europe.

Series production: Jonathan North and Lucie Jackson.

This edition of the Health Systems in Action Insight for the United Kingdom was written by Mark Dayan, Stephanie Kumpunen, Sarah Reed and Erica Richardson.

The Health Systems in Action series

The Health Systems in Action Insights series supports Member States in the WHO European Region that are not in the European Union.

The Insights for each country are intended to:

- provide core information and data on health systems succinctly and accessibly;
- outline the country health system context in which WHO Europe's Programme of Work is set;
- flag key concerns, progress and challenges; and
- build a baseline for comparisons, so that Member States can see how their health systems develop over time and in relation to other countries.

The series is co-produced by the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies.

It draws on the knowledge and understanding of the WHO Country Offices and of the Division of Country Health Policies and Systems (CPS), the WHO Barcelona Office for Health Systems Financing and other WHO/Europe technical programmes; as well as the Health Systems in Transition series and the work of the European Observatory on Health Systems and Policies.

The Insights follow a common template that provides detailed guidance and allows comparison across countries. The series is publicly available on the websites of the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies (eurohealthobservatory.who.int).

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HEALTH SYSTEMS IN ACTION

INSIGHTS: UNITED KINGDOM

Key points

- Universal health coverage is a core tenet of the National Health Service (NHS), which was founded in 1948 on the principle that comprehensive care should be accessible to all based on clinical need and not the ability to pay.
- Each country of the United Kingdom of Great Britain and Northern Ireland has devolved responsibilities for health and social care, meaning that the ways in which services are designed, delivered and regulated vary across England, Scotland, Northern Ireland and Wales.
- Health services in the United Kingdom are primarily funded through general taxation and are governed by a complex set of regulators operating at the local, regional and national levels.
- Increased spending due to the COVID-19 pandemic pushed public spending on health to 11% of GDP in 2022. However, a prolonged period of government funding restraint has limited investment in long-term priorities such as infrastructure, workforce and technology, making it difficult for services to meet patient demand.
- Reflecting the NHS founding principles, the United Kingdom reports some of the lowest rates of out-of-pocket (OOP) and catastrophic health spending in Europe. However, there are gaps in coverage that place people at financial risk and drive differences in access by socioeconomic status, particularly for services such as dentistry and eye care that are not well covered by the NHS.
- Access to care is impeded by long waits for planned hospital care, which have been emerging for over a decade, but have grown particularly rapidly since the COVID-19 pandemic. Access to primary care appointments has also worsened.
- The United Kingdom has relatively low rates of both doctors and nurses compared to EU countries. This reflects historic problems in planning and retention. Reliance on both doctors and nurses trained abroad is high, partly as a response to a long history of shortages.
- Life expectancy in the United Kingdom was not improving even before the COVID-19 pandemic. There are wide variations in health outcomes reflecting socioeconomic inequalities and increasing poverty rates that have profound consequences for population health, including infant and maternal mortality rates, which are above the EU averages.
- Noncommunicable diseases (NCDs), namely cancer, ischaemic heart disease and dementia, are the leading causes of death in the United Kingdom, and tobacco use is the main risk factor. Although tobacco use has fallen, vaping is increasingly widespread, especially among young people. New policy ambitions to be 'smokefree' by 2030 seek to address this issue directly.

1 ORGANIZING THE HEALTH SYSTEM

Health services are governed by a complex set of regulators

The primary source of health financing is general taxation. Regulation involves a number of regulators at national, regional and local levels. The devolved governments in Scotland, Wales and Northern Ireland are responsible for setting national strategies and standards for the National Health Service in each country. In England, this responsibility sits with the Department of Health and Social Care (DHSC), which also has some control over matters affecting the whole United Kingdom, including some additional responsibilities linked to the Crown Dependencies and Overseas Territories. The DHSC works closely with NHS England at the national level, an arm's-length body that provides operational oversight for health services in England and has broader responsibility for performance improvement.

There has been a growing focus on integration between health and social care

The integration of health and social care has become a major focus in all constituent countries of the United Kingdom. In England, 42 Integrated Care Systems (ICSs) plan and fund most local NHS services and develop strategies for improving population health and well-being. Each ICS is a local partnership that brings health and care organizations together to develop shared plans and joined-up services. ICSs are formed by NHS organizations (Integrated Care Boards, NHS providers), Integrated Care Partnerships (ICPs) and upper-tier local councils in that area. These also include the voluntary sector, social care providers and other partners with a role in improving local health and well-being. ICSs are accountable to NHS England and include representatives from their members from across the NHS, local authorities and other local public services. ICSs have evolved throughout the 2010s and were established as statutory in 2022. Their introduction marked a formal shift away from a governance approach based on individual organizational autonomy to one where services are expected to collaborate and have greater joint accountability for the health and well-being of their local population (Anderson et al., 2022).

In Scotland, 14 territorial NHS Boards have prime responsibility for delivering and managing front-line health services in their localities. Since 2016, NHS Boards have been required to work with local authorities through 31 integration authorities to plan and purchase social and community care. In Wales, seven Local Health Boards (LHBs) plan and deliver health services in their local areas. LHBs are required to partner with local authorities to coordinate services and pool some funding to better integrate health and social care through Regional Partnership Boards. In Northern Ireland, a new planning model will be

rolled out in 2024 that creates a new Integrated Care System. The new Integrated Care System has two key elements: the first focuses on better integration within Health and Social Care to plan and manage integrated, continuous care based on the needs of the population. The second sees the establishment of local partnerships, through the establishment of five Area Integrated Partnership Boards, which will focus on prevention, early intervention and community health and well-being.

While there have been ongoing efforts in each country to enhance person-centred care (Reed et al., 2021), challenges such as resource constraints and varying levels of implementation have hindered progress and continue to be priorities for further improvement.

Universal health coverage remains a basic tenet of the NHS

The NHS was established in 1948 with the underlying principle that care should be comprehensive with access based on clinical need and not the ability to pay. Entitlement to NHS services is based on residency status. Everyone legally resident in the United Kingdom can access hospital and specialist services free at the point of use. Furthermore, some services, such as emergency care, primary care and some community services (i.e., urgent family planning, sexual health services), are provided free to everyone regardless of residency status. 'Overseas visitors' or people who enter the United Kingdom temporarily may be required to pay for some community, secondary or acute NHS services. Some other non-residents are also entitled to all NHS services without charge, including refugees and asylum seekers.

Each country in the United Kingdom determines their own user charges. User charges apply primarily to dentistry and eye care for working-age people (for example, vision examinations or corrective lenses), though in England adults are also required to pay a fixed co-payment per prescribed item for outpatient medicines. Broad exemptions apply to user charges, including for children, full-time students, older adults, low-income adults, pregnant people, and people with certain physical and mental health conditions.

2 FINANCING AND ENSURING FINANCIAL PROTECTION

Health spending per person has increased

Public spending per person has risen from US\$2941 in 2010 to US\$5109 in 2021 and current health spending, including private OOP payments and voluntary health insurance, has risen from US\$3646 to US\$6266 (Fig. 1). This reflects a particularly sharp increase in public spending since 2020, due to the COVID-19 pandemic and a subsequent surge in spending to deal with the crisis. The drastic reduction in economic activity during the pandemic is reflected in the ratio of current health spending to GDP, which increased from 10% in 2019 to 12.4% in 2021, before falling back to 11.3% in 2022.

The figures below show the United Kingdom in comparison to averages across the 27 EU Member States; the WHO European Region of 53 countries; and the 33 of these countries classified as high income (WHO, 2024b). These averages are not weighted for population or economy size.

The increase in public spending on health as a share of GDP was much more pronounced in the United Kingdom than in other high-income countries (Fig. 2). This may reflect the NHS having limited capacity going into the pandemic relative to other countries' health systems, as well as a costly system for testing and tracing COVID-19 (Reed, Schlepper & Edwards, 2022). However, this increase represents a much slower rate of growth in public spending on health than was seen before the government introduced a policy of austerity in 2010. In real terms, public spending on health grew 1.9% per year on average between 2009 and 2018, and by 2.4% between 2019 and 2024, compared to the long-term historical average of around 3.6% per year (Stoye, Warner & Zaranko, 2024).

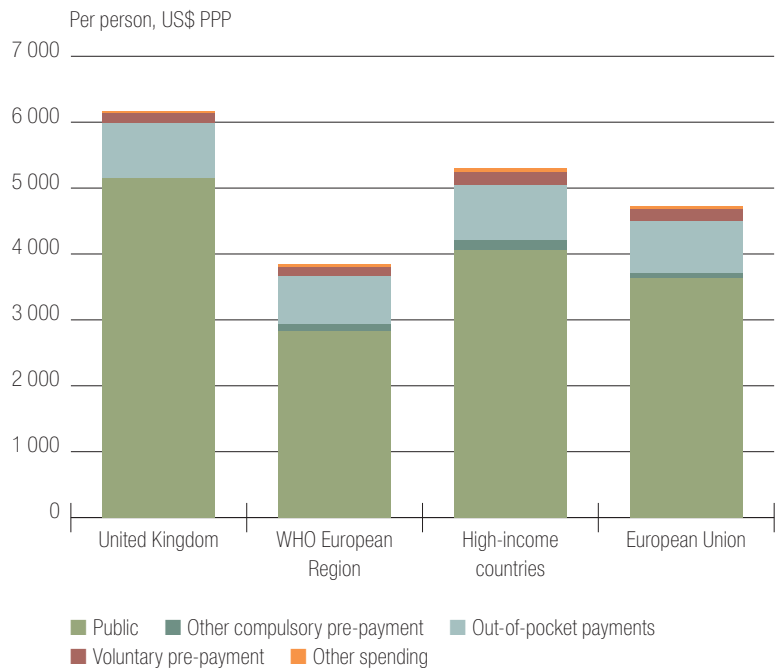
Health services are mainly funded through general taxation

In the United Kingdom, around 80% of the NHS budget comes from general taxation. Most of the rest is derived from "National Insurance", an additional compulsory income tax which also determines qualification for the state pension, and a small proportion comes from patient charges for services like prescriptions and dental care. Public spending on health as a proportion of current health spending has remained relatively unchanged over the last two decades at around 80%.

The NHS has consistently been prioritized within government spending, with approximately 20% of government spending on health (growing from roughly 16% in 2002) (Anderson et al., 2022). Even though the policy of austerity implemented since 2010 resulted in smaller increases in health spending, the NHS budget was protected relative to other public services such as

Fig. 1

The United Kingdom spends more per person on health than many other European countries

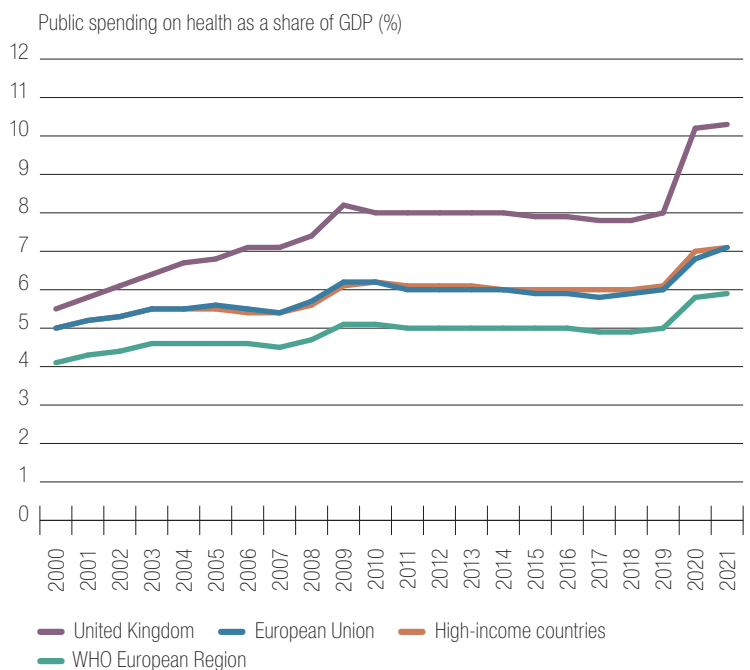


Source: WHO, 2024b.

Notes: 2021 data. Public refers to transfers from government budgets and social health insurance contributions. Other compulsory pre-payment refers to premiums for mandatory health insurance schemes in Belgium, Finland, France, Germany, the Netherlands and Switzerland. Other spending includes external funding and some other marginal spending. PPP: purchasing power parity.

Fig. 2

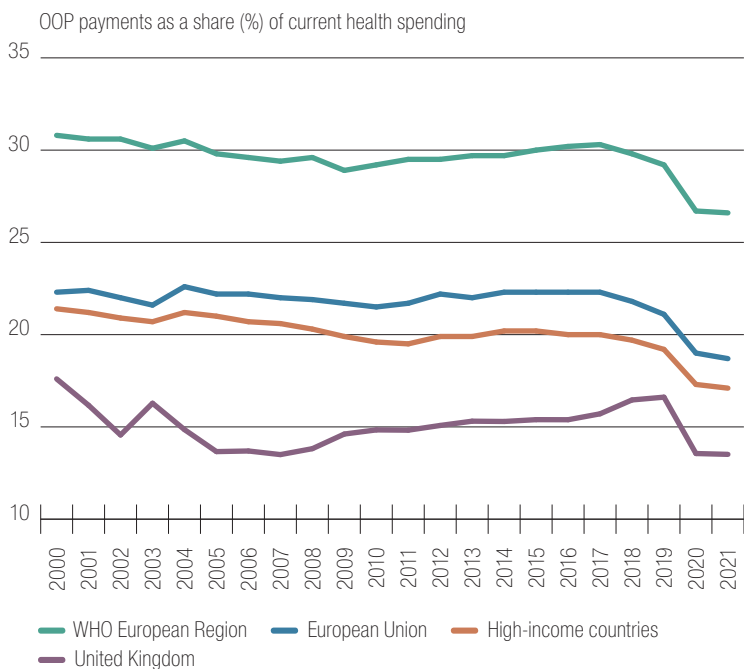
Public spending on health as a share of GDP increased substantially during the COVID-19 pandemic



Source: WHO, 2024b.

Fig. 3

OOP spending is low in the United Kingdom relative to most other European countries



Source: WHO, 2024b.

social care, which experienced real-term spending cuts as local authority grants were sharply reduced. Before the COVID-19 pandemic, private spending accounted for 20% of current health spending. Spending on voluntary health insurance has steadily fallen, from 4% of current health spending in 2008 to 2.4% in 2021, while OOP payments increased from a low of 13.5% in 2007 to 16.6% in 2019, before falling back to 13.5% in 2021 during the COVID-19 pandemic (Fig. 3). However, there are clear signs of an increase in OOP spending in 2022 and 2023, not yet captured in internationally comparable data (Dayan, Gainsbury & Bagri, 2024).

Since the COVID-19 pandemic, the United Kingdom government has spent more on health as a share of its economy than any other EU country. This increase in government spending happened alongside relative low GDP growth, which has altered the country's health-spending-to-GDP ratio. While this is a common pattern across European countries, it has been more pronounced in the United Kingdom. The fact that the government now spends more as a percentage of GDP than other countries is less an indication of the relative prioritization of health, and more a reflection of how the economy and health spending in the United Kingdom have changed in the years during and since the peak of the pandemic.

Just over half of public spending on health goes to the hospital sector

There are several complexities in determining how resources are distributed across levels of care in the United Kingdom, in part because the definitions used

in internationally comparable databases correlate poorly to what is traditionally understood as specialist, primary and social care in the NHS (Anderson et al., 2022). According to the DHSC's annual account, half of public spending on health in England is on hospital services, providing inpatient and outpatient secondary care (Gainsbury & Julian, 2024).

Using WHO data, in 2021 in the United Kingdom 24% of current health spending went to outpatient care, followed by inpatient care (23%), long-term care (17%), medical goods including medicines (9%), day case care (4%), home-based care (2%), ancillary services including laboratory services and imaging (2%), and governance (2%). Spending on preventive care was anomalously high at 12% in 2021 due to increased spending on immunization programmes and epidemiological surveillance during the COVID-19 pandemic; in 2019 preventive services accounted for 5% of current health spending.

Box 1

There is scope for improving allocative efficiency in the health system by delivering more care in outpatient settings

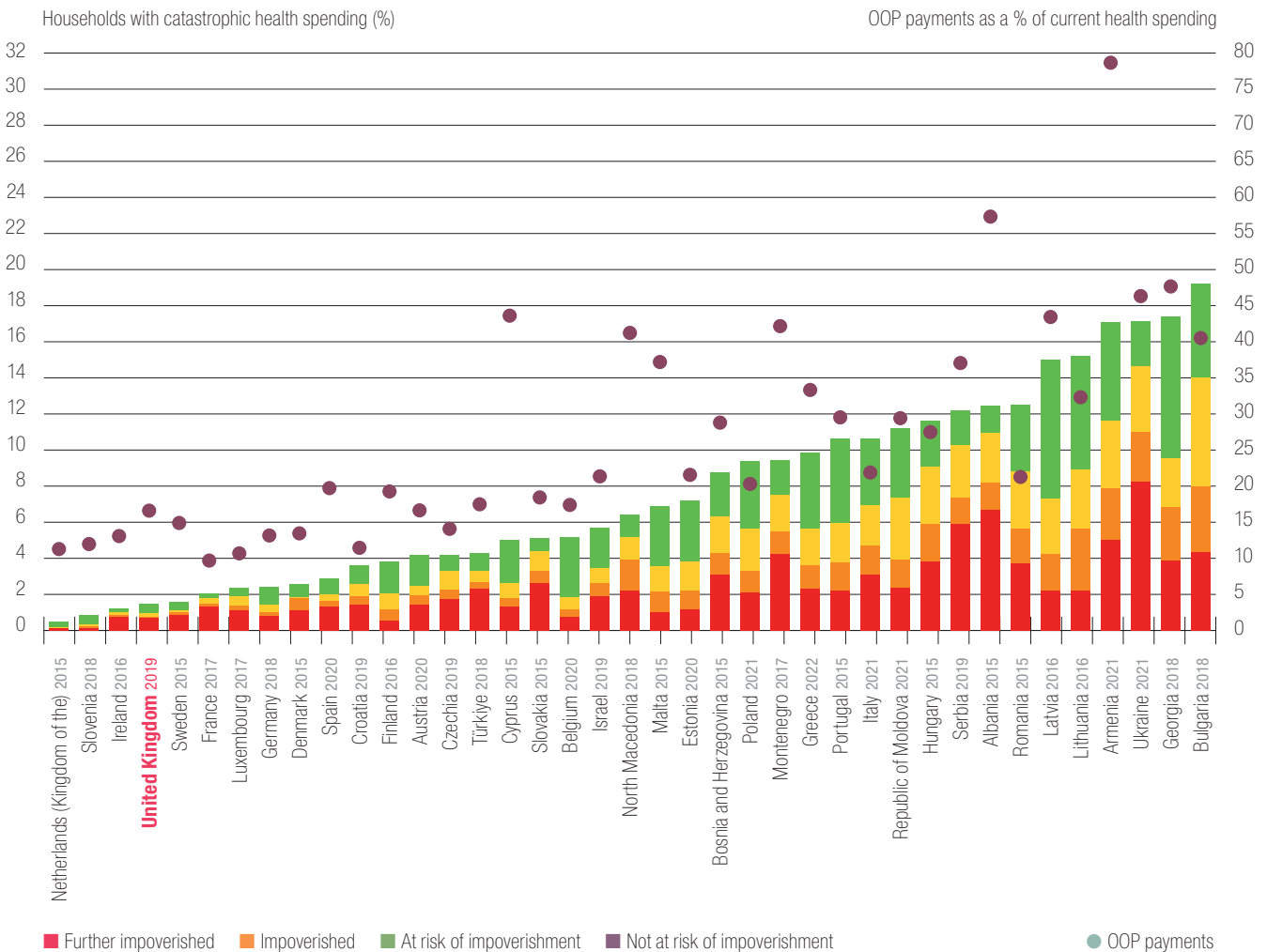
Although the United Kingdom has developed robust methods of health technology assessment, this has not necessarily translated to broader, national-level decisions about how to allocate resources between sectors. The continued prioritization of treatment over prevention has contributed to the reduction in public health capacity, as funding for public health services has fallen relative to front-line services over the last decade (Finch, Bibby & Elwell-Sutton, 2018).

However, within the secondary care sector, a major strength of the NHS across the United Kingdom is flexible resource allocation via local commissioning bodies or health boards based on sophisticated formulae which explicitly account for differing geographic needs. Each country has its own formula that is regularly refined, drawing on routinely collected data to ensure they are responsive to changing health needs. The benefits gained through systematic resource allocation in all four countries are an even distribution of financial risk (though financial control is currently very poor in all of the United Kingdom's countries) and consideration of equity of access by allocating resources based on need.

Source: Anderson et al., 2022.

Fig. 4

Catastrophic health spending and OOP spending are low in the United Kingdom relative to other countries



Source: WHO Regional Office for Europe, 2024.

Notes: The data on OOP payments are for the same year as the data on catastrophic health spending (except for Greece, where data on OOP spending are from 2021). A household is impoverished if its total spending falls below the poverty line after OOP payments; further impoverished if its total spending is below the poverty line before OOP payments; and at risk of impoverishment if its total spending after OOP payments comes within 120% of the poverty line. The poverty line used here is a relative line reflecting basic needs (food, housing, utilities).

A long-term aim of the NHS has been to shift more resources into the community and outside hospitals, with the aims of preventing unnecessary hospital admissions and freeing up beds for patients who need them the most (Box 1).

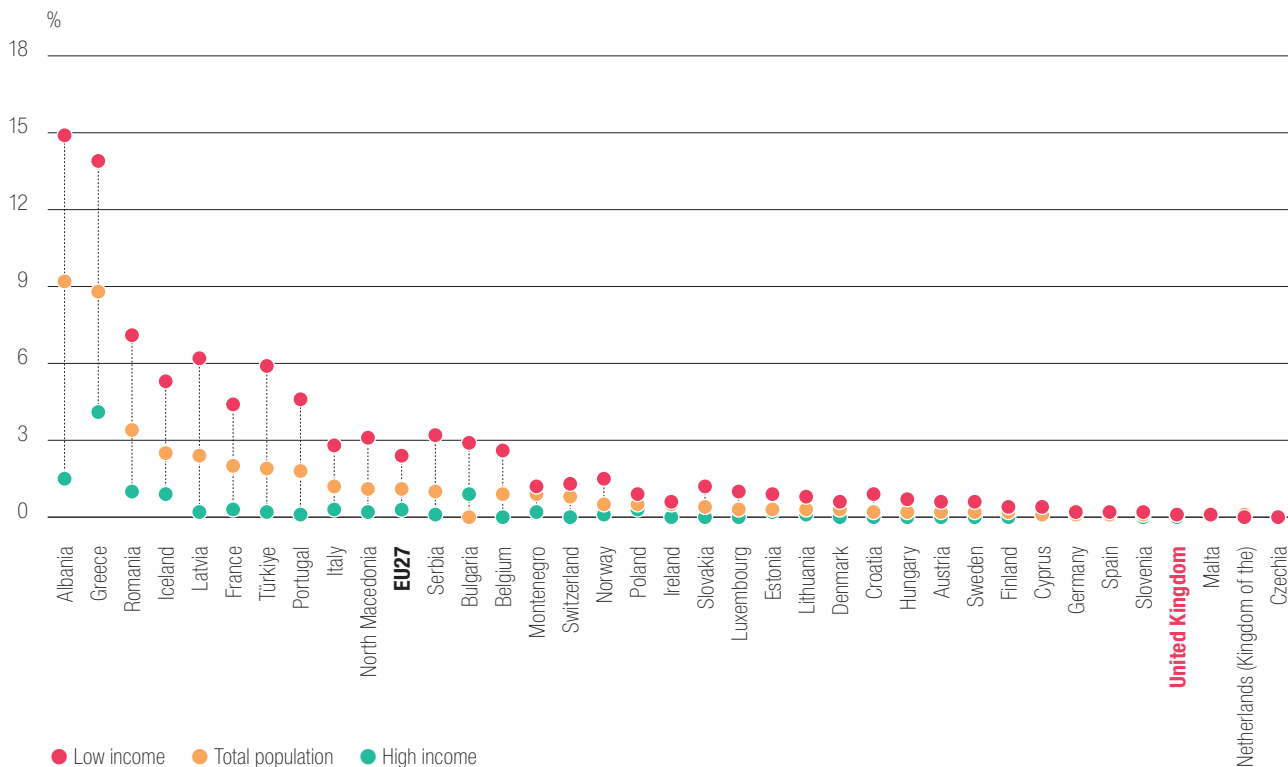
Overall there is very good protection against the financial consequences of ill-health

Because the NHS provides most services free at the point of use, irrespective of the ability to pay, the United Kingdom reports some of the lowest rates of OOP payments and catastrophic health spending in Europe (Fig. 4). Levels of unmet need due to cost are also comparatively low (Fig. 5).

However, some gaps in coverage remain, placing people at financial risk and resulting in differences in access by socioeconomic status. There are charges for NHS dental services and, even where exemptions exist, the supply of dentists willing to treat NHS patients is so limited that many people must either pay the full cost out of pocket to access private services or experience long waits for publicly financed treatment. Long waits for hospital care that pre-dated the pandemic, but have grown worse since its arrival, may also be contributing to a growing number of people paying privately for care. Between 2019 and 2023, there has been a 30% increase in the number of people paying out of pocket for hospital care across the United Kingdom (Nuffield Trust, 2024). The impact of this is not yet seen in internationally comparable data but may mark a significant shift.

Fig. 5

Unmet medical care needs due to cost are comparatively low in the United Kingdom



Source: Eurostat, 2024a.

Notes: Data refer to unmet needs for a medical examination or treatment due to costs among people aged 16 and over. High-income refers to people in the richest income quintile. Low-income refers to people in the poorest income quintile. Caution is required in comparing the data across countries as there are some variations in the survey instrument used. Data refer to 2022, except Albania and Türkiye (2021), North Macedonia (2020) and Iceland and the United Kingdom (2018).

3 GENERATING RESOURCES, PROVIDING SERVICES AND ENSURING ACCESS

Austerity has hampered investment in long-term priorities such as infrastructure, workforce and technology

The overall number of hospital beds per population is lower in the United Kingdom than in most other European countries, with a consistent decline over time. A similarly declining trend is seen in many countries that have tried to bring down rates of hospitalization and length of hospital stay – which has been reducing in the United Kingdom since 2000, with the proportion of day cases also rising. However, the United Kingdom has consistently had a lower rate of hospital beds throughout this period (OECD, 2023). The rate declined from 408 acute care beds per 100 000 population in 2000 to 230 in 2021, compared to a decline in the EU from 635 acute care beds per 100 000 population in 2000 to 494 in 2020 (Fig. 6).

Pressure from the COVID-19 pandemic highlighted that the NHS has little excess bed capacity, particularly in critical care, to respond to surges in demand. This has also been apparent during periods of seasonal pressure, when the government has had to inject short-term funding to purchase escalation or step-down beds to free up more space for people in hospital (Anderson et al., 2022). As part of NHS England's Delivery plan for recovering urgent and emergency care services (2023), the government funded an additional 5000 staffed, permanent beds in England to alleviate these pressures and increase baseline capacity in the system.

The rate of hospital beds also varies across the United Kingdom, with England having lower numbers of hospitals beds per 1000 population (2.4) than Scotland (3.8), Wales (3.4) and Northern Ireland (3.1). It is difficult to explain these variations, but likely that a range of political, historical, managerial and financial factors have contributed (Anderson et al., 2022).

Beyond hospital beds, capital investment in other infrastructure such as hospital buildings, equipment and technology has also tended to be low in the United Kingdom compared to other high-income countries (OECD, 2023). This has translated into fewer pieces of equipment such as CT scanners and MRI machines per person than comparable health systems. In 2024,

United Kingdom governments both before (DHSC, NHS England & Atkins, 2024) and following (HM Treasury, 2024) the July general election committed extra capital spending to improve the level of provision.

Investment in the NHS has been uneven over time. In recent years, countries of the United Kingdom have all seen local trusts and boards unable to balance expenditure and costs, and running up deficits, often filled by emergency cuts to budgets for both capital and improvement. This is partly why the total value of delayed or “backlog” maintenance work in the English NHS has grown from £5.4 billion in 2013/14 to over £12.5 billion in 2022/23 (Stoye et al., 2024).

The United Kingdom has comparatively few doctors per capita

Compared to the averages in the EU and the WHO European Region, the United Kingdom has a marginally higher number of nurses per 100 000 population, but a much lower number of physicians (Fig. 7), reflecting problems in training and planning.

Despite being slightly above European averages, there is a shortage of nurses to meet patient demand. Contributing factors include a bottleneck in training places, a lack of workforce planning in England based on robust projections (until recently), and high rates of staff leaving towards the start of their careers (Buchan et al., 2020; Rolewicz, Palmer & Lebont, 2024).

The NHS Long Term Work Force Plan for England (2023) stated that “The lack of a sufficient workforce, in number and mix of skills, is already impacting patient experience, service capacity and productivity, and constrains our ability to transform the way we look after our patients”. It committed to a large expansion in training, doubling medical school places and close to doubling adult nurse training places.

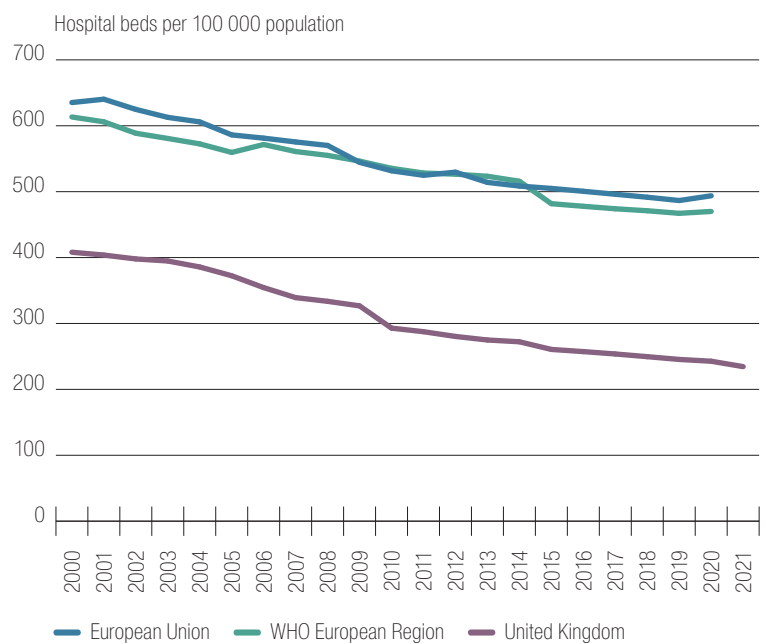
The United Kingdom has a historic and ongoing problem with geographical inequalities in the distribution of its primary care workforce. More deprived areas of England tend to have fewer NHS general practitioners (GPs) per person than less deprived areas, despite generally higher levels of need (Rolewicz, Palmer & Lebont, 2024). England as a whole has fewer GPs per person than Scotland, Wales and Northern Ireland.

Ongoing funding and workforce issues have made access to care a growing challenge

In the United Kingdom, a patient's first point of contact with the NHS tends to be in primary care. Primary care teams are often composed not only of doctors, but involve a broad range of roles, including health visitors, nurses and pharmacists. These teams provide care for a broad set of issues, including routine diagnostic services, minor surgery, family planning, ongoing care for patients with chronic conditions, preventive services, and referrals for more specialized care.

Fig. 6

The United Kingdom has a very low rate of hospital beds per population



Source: WHO, 2024c.

The pandemic caused considerable changes to how patients access GP services, and many practices rapidly adopted a ‘digital first’ service. This meant that all consultations, where possible, took place by phone or video. There was also a move towards ‘total triage’, where patients provided some information on their reasons for contacting the practice and were triaged before making an appointment. These changes have been absorbed into routine practice now, with services continuing to offer remote appointments and using a triage model.

Inequities in access to primary care are due to persistent GP shortages and large geographical variation in their availability. In England, for instance, one study found that, after accounting for differences in need, GPs in poorer areas are on average responsible for 10% more patients than their counterparts working in richer areas (Fisher et al., 2022). Recent patient surveys suggest that, while many patients find it easy to contact their GP by telephone, this proportion fell from 81% in 2012 to just 50% in 2023 (Nuffield Trust, 2023a).

Routine childhood vaccination services are provided in primary care and are provided free-of-charge. However, vaccination coverage is not at the WHO target threshold of 95% for all essential childhood vaccines and coverage rates have been steadily falling. In 2023, only 90% of infants had received the first dose of the measles-containing vaccine, down from 93% in 2015, and only 85% had received their second dose. For the full course of three vaccinations against diphtheria, tetanus and pertussis, 92% of children were covered in 2023 (WHO, 2024a). In 2022, poliovirus was discovered in London by routine sewage monitoring, highlighting

Fig. 7

The United Kingdom has fewer physicians per 100 000 population than the EU average

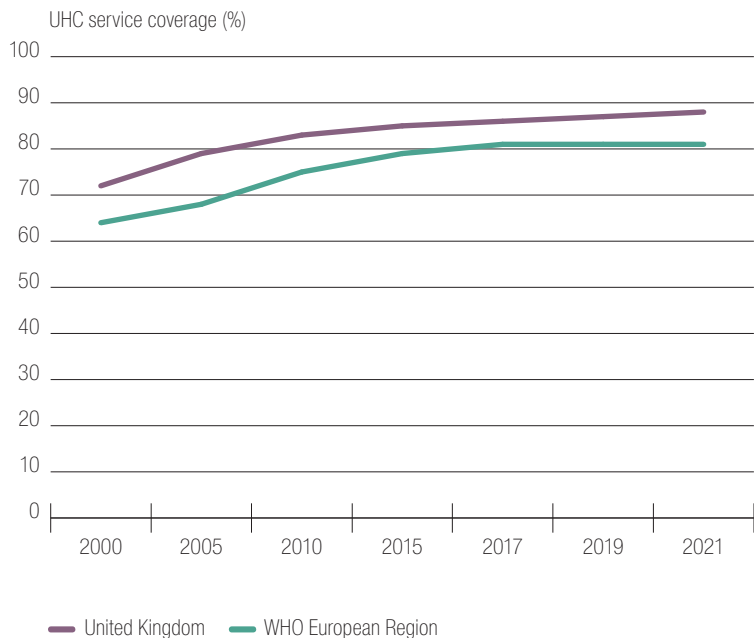


Source: WHO, 2024d.

Note: Densities were multiplied by 10 to calculate the density per 100 000 population. Averages are based on latest available years.

Fig. 8

The United Kingdom scores high on the UHC service coverage index



Source: WHO, 2024c.

Note: UHC service coverage index, defined as the average estimated coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health; infectious diseases; NCDs; and service capacity and access; among the general and the most disadvantaged populations.

the issue of large numbers of under-vaccinated children living in some densely populated areas of the capital. In response, the NHS has strengthened ongoing work to improve uptake nationally in the routine childhood programme and organized a polio vaccination booster campaign in London. Polio vaccination coverage in the United Kingdom was 97% in 2023.

The accessibility of essential services is very good

The universal health coverage (UHC) service coverage index measures access to essential services. In the United Kingdom it increased swiftly between 2000 and 2010, from 72 to 83 out of 100, but progress then slowed in line with the WHO European Region average, reaching 88 in 2021 (Fig. 8). Service capacity and access have remained very high over the same time period (98 in 2021), but the UHC service coverage sub-index on noncommunicable diseases has only improved from 52 in 2000 to 68 in 2021. The sub-index on infectious diseases increased from 61 in 2000 to 91 by 2015, reaching 98 by 2021, which is extremely high in global comparison.

The strength of infectious diseases coverage in the United Kingdom is highlighted by the UNAIDS 95:95:95 target of ensuring 95% of people living with HIV are aware of their status, 95% of these are on treatment and 95% of those on treatment will achieve viral suppression by 2025 (Fig. 9). In the United Kingdom in 2022, 94% of people living with HIV were estimated to be aware of their status and of these 98% were on treatment, with 97% of those on treatment achieving viral suppression.

Fig. 9

The United Kingdom has high service coverage for HIV



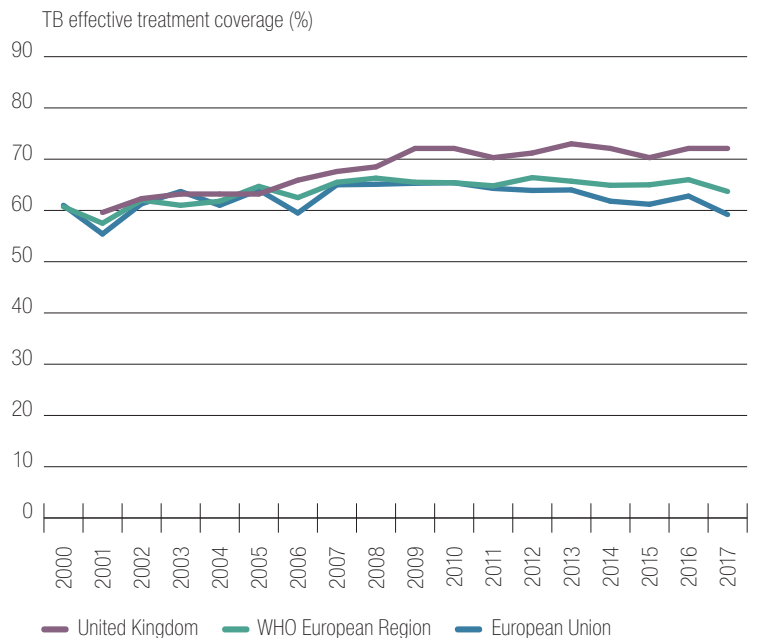
Source: National AIDS Trust (<https://www.nat.org.uk/about-hiv/hiv-statistics>).

Note: ART: antiretroviral therapy; UNAIDS: Joint United Nations Programme on HIV/AIDS.

Access to tuberculosis (TB) services is also good overall in the United Kingdom. In 2017 it was estimated that 72.1% of TB cases were detected and successfully treated, which was well above the EU average of 59.2% and the average of 63.7% for the WHO European Region in the same year (Fig. 10). Ease of access and availability of services can be a problem, however, particularly for some at-risk communities. For example, people with greater social risks such as homelessness have significantly lower TB treatment success rates than people without (77% compared to 84% in England in 2022) (United Kingdom Health Security Agency, 2024).

Fig. 10

The United Kingdom has relatively high coverage for effective tuberculosis treatment



Source: WHO, 2024c.

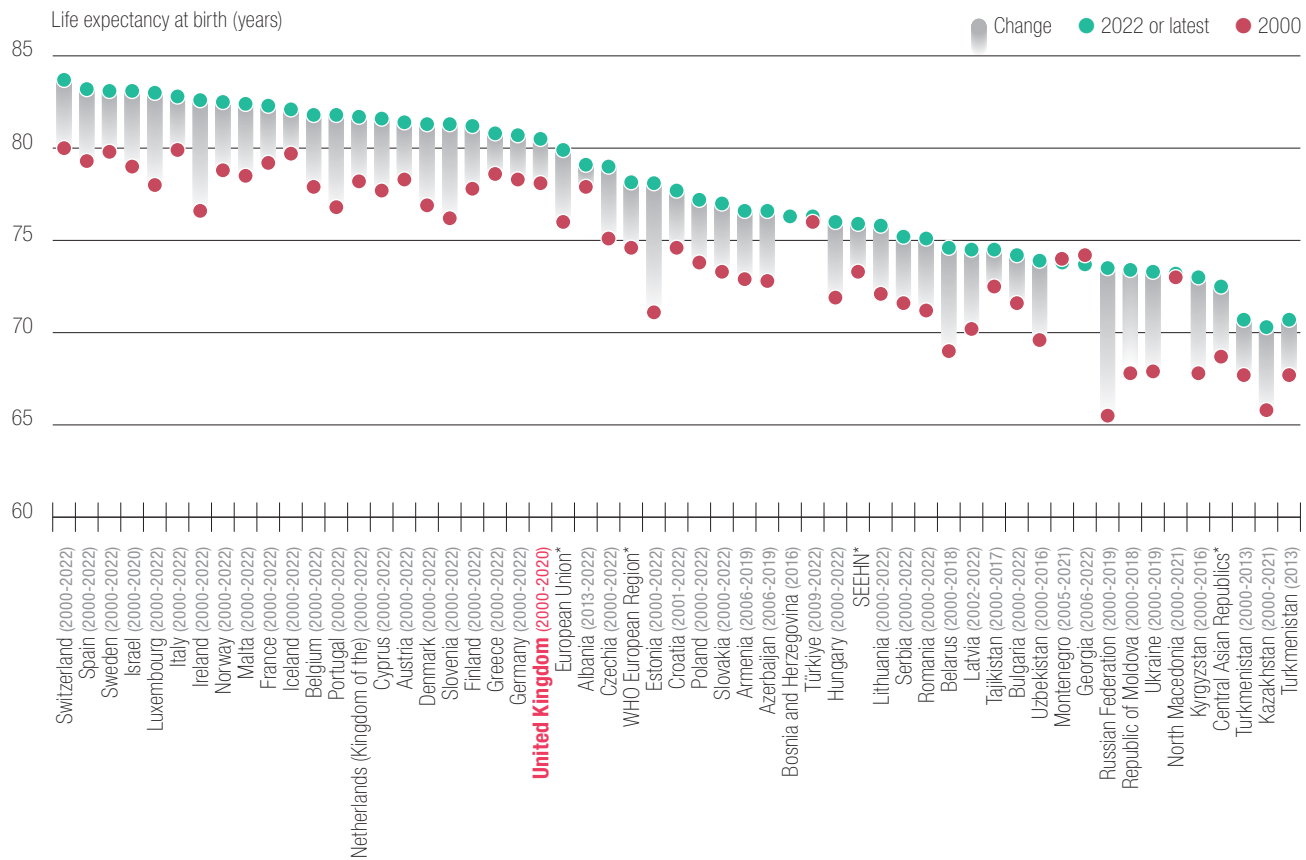
Note: Proportion of TB cases detected and successfully treated (estimate).

4 IMPROVING THE HEALTH OF THE POPULATION

Life expectancy declined during the COVID-19 pandemic

Life expectancy at birth in the United Kingdom increased between 2000 and 2019 from 78.1 to 81.8 years, declining to 80.5 years in 2020, the first year of the COVID-19 pandemic (Fig. 11). According to data from the Office for National Statistics, life expectancy in the United Kingdom increased by 0.7 years for males and 0.5 years for females between 2020 and 2022. Since approximately 2011, i.e. even before the impact of the COVID-19 pandemic, the rate of increase in life expectancy in the United Kingdom slowed (ONS, 2020).

Fig. 11
Life expectancy at birth increased between 2000 and 2020



Sources: Eurostat, 2024b, for EU/EEA countries, Albania, Montenegro, North Macedonia, Serbia, Armenia, Azerbaijan, Georgia and Türkiye; WHO Regional Office for Europe, 2024b, for all others.

Notes: * averages are based on years with data available. The South-eastern Europe Health Network (SEEHN) includes Albania, Bosnia and Herzegovina, Bulgaria, Israel, Montenegro, North Macedonia, the Republic of Moldova, Romania and Serbia. The latest internationally available data for the United Kingdom are for 2020 (the first year of the pandemic), while for many other countries data are available in international databases for 2022 (the first post-pandemic year).

Several factors have been suggested as contributing to the stalling increase in life expectancy, including: widespread capacity issues for acute beds in NHS hospitals; austerity measures introduced since 2010 (which have resulted in funding cuts for local authorities and subsequent reductions in social care service provision which have been associated with increased mortality rates, particularly affecting older people and those living in poverty); and considerable cuts to public health services in England (Anderson et al., 2022).

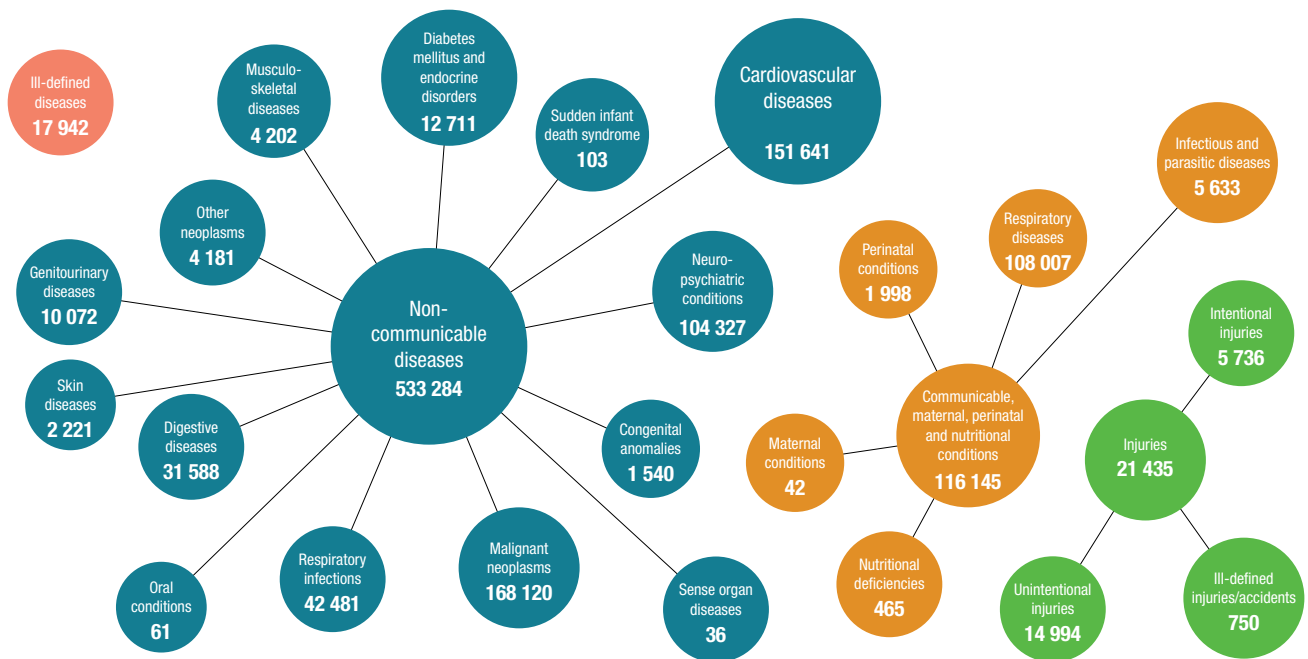
Within the United Kingdom, England consistently reports higher life expectancy than Scotland, Wales and Northern Ireland. Life expectancy at birth for males in 2020–2022 was 78.8 years in England, 76.5 years in Scotland, 77.9 years in Wales and 78.4 years in Northern Ireland. For females in 2020–2022 it was 82.8 years in England, 80.7 years in Scotland, 81.8 years in Wales and 82.3 years in Northern Ireland (ONS, 2024). As well as variation between the countries of the United Kingdom, life expectancy at birth varies sub-nationally and is affected by other factors, including levels of deprivation (ONS, 2024).

Infant and maternal mortality rates exceed EU averages

The maternal mortality rate in the United Kingdom in 2020 was 9.8 deaths per 100 000 live births. Despite a general decline since the 1980s, this rate was still well above the EU average (6.4 in 2020) and the rates in Germany and France (4.4 and 7.9 respectively). Moreover, in the United Kingdom the maternal mortality rate has been steadily increasing since 2012 when it was 8.3 per 100 000 live births and the EU average was 7.1; the rates in Germany and France in 2012 were 5.5 and 9.0 respectively.

Fig. 12

NCDs are the leading cause of death in the United Kingdom



Source: WHO, 2024e.

Note: Overview of the distribution of causes of total deaths grouped by category. United Kingdom data from 2020.

The infant mortality rate in the United Kingdom was 3.7 deaths per 1000 live births in 2021. Research has found that the babies at the highest risk of infant mortality are those born with a low birthweight (less than 2500g), of Black ethnicity, or to a mother aged under 20 years (ONS, 2023a). The infant mortality rate in the United Kingdom is higher than the EU average (3.2 in 2021), but also higher than the rates in Germany (3.0 deaths per 1000 births) and France (3.4 deaths per 1000 births). England has had several public inquiries and investigations into maternal and neonatal safety within hospitals since 2015, and into the significant disparities in outcomes between different ethnic groups, resulting in numerous recommendations for improving services, but the impacts of changes have not been studied at a system level.

NCDs are the leading cause of death

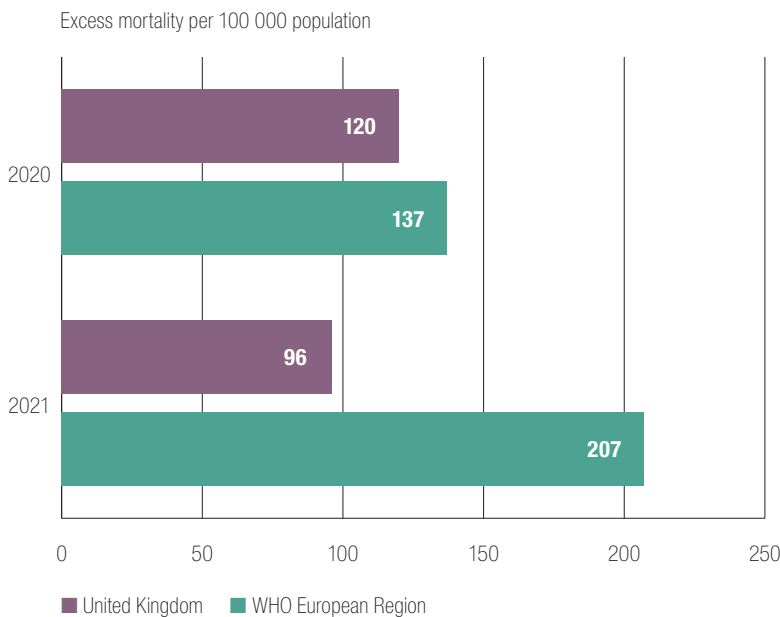
The leading causes of death in the United Kingdom in 2020 were cancers, cardiovascular diseases, respiratory diseases (mainly deaths from COVID-19) and neuropsychiatric conditions such as dementia (Fig. 12). Generally, the leading causes of death for England, Wales, Scotland and Northern Ireland follow the same trend: there have been decreases in the number of deaths resulting from stroke and ischaemic heart disease (IHD) and an increase in deaths resulting from dementia and Alzheimer's disease (ONS, 2020).

Excess deaths due to the COVID-19 pandemic were lower than in the WHO European Region overall

The United Kingdom did initially experience a very high death rate associated with COVID-19, due to a delayed response and pressures on the NHS. The fall in the death rate in the later phases of the pandemic has been attributed to the success and speed of the immunization programme (Anderson et al., 2022). Excess deaths associated with the COVID-19 pandemic in the United Kingdom were 120 and 96 deaths per 100 000 in 2020 and 2021 respectively, while the WHO European Region averages were 137 and 207 deaths per 100 000 in the same years (Fig. 13). The gap can be partially explained by some countries in the WHO European Region having much lower levels of vaccination during the pandemic.

Fig. 13

Excess deaths associated with the Covid-19 pandemic decreased between 2020 and 2021



Source: WHO, 2023.

Note: Excess mortality from all causes of death, defined as the difference between the total number of deaths and the number that would have been expected in the absence of a crisis (for example, the COVID-19 pandemic). This difference is assumed to include deaths attributable directly to COVID-19 as well as deaths indirectly associated with COVID-19 through impacts on health systems and society.

Premature mortality from NCDs is declining

The number of premature deaths (among people aged 30–69 years) from four major NCDs (cardiovascular diseases, cancers, diabetes mellitus and chronic respiratory diseases) fell in the United Kingdom from 349 per 100 000 population in 2000 to 231 in 2021.

Box 2

The Tobacco and Vapes Bill

In 2017, and again in 2019, the government announced the smokefree 2030 ambition for England – which would be achieved when adult smoking prevalence falls to 5% or less. A government-commissioned independent review found that “without further action, England will miss the smokefree 2030 target by at least 7 years, and the poorest areas in society will not meet it until 2044” (Khan, 2022). The review set

The rate in the United Kingdom was consistently lower than the WHO European Region and EU averages during that timeframe (see Fig. 14).

COVID-19 dominated the burden of disease in 2021

A disability-adjusted life year (DALY) provides an indicator of the burden of disease in a population, as one DALY corresponds to the loss of one year in full health due to premature mortality and years lived with a disability. The largest contributor to DALYs in the United Kingdom in 2021 was COVID-19, followed by IHD and lower back pain (Fig. 15).

Tobacco use remains the leading behavioural risk factor

While the percentage of adults in the United Kingdom who are estimated to be current smokers has fallen steadily from 36.2% in 2000 to 12.5% in 2023, tobacco use continues to negatively impact population health (Fig. 16). The number of daily or occasional e-cigarette users increased from 7.7% to 8.7% between 2021 and 2022 (ONS, 2023b). E-cigarette use is highest among those aged 16–24 years in England, Wales and Scotland combined, where the percentage of people who are daily or occasional vapers increased from 11.5% in 2021 to 15.5% in 2022. Creating a ‘smokefree’ England has become an important policy priority (Box 2).

Other behavioural risk factors include high systolic blood pressure, dietary risks and high body mass index (Fig. 16). It was estimated that just over one quarter of adults in the United Kingdom, around 14.4 million people, had either diagnosed or undiagnosed high blood pressure in 2021 (Anderson et al., 2022). The Health Survey for England 2021 also estimated that 26% of adults in England were obese (NHS Digital, 2022).

out a package of 15 recommendations. One of the “critical must-do recommendations” was to raise the smoking age by one year, every year, until it applies to the whole population, for which legislation was introduced in October 2023 (DHSC, 2023). The new policy also aimed to restrict and regulate vape flavours, packaging and point of sale displays, and to end the sale of disposable vapes. The Tobacco and Vapes Bill did not pass through Parliament before the 2024 General Election, and has now been reintroduced.

Poverty and widening income inequality remain the core social determinants of ill-health

The United Kingdom has one of the highest levels of income inequality in Europe, with millions of people continually at-risk of poverty (Anderson et al., 2022). In 2022/23, 11.4 million people (17% of the population) were living in relative poverty before housing costs and 14.3 million after housing costs (21%). This includes 3.2 million children (22% of children in the United Kingdom) before housing costs and 4.3 million after housing costs (30%). Moreover, 9.5 million people (14% of the population) were living in absolute poverty before housing costs and 12.0 million (18%) were living in absolute poverty after housing costs (Francis-Devine, 2024). Absolute poverty, and absolute child poverty, are likely to continue to increase because real incomes are falling (Francis-Devine, 2024). Additionally, the number of people in food-insecure households rose by around 2.5 million people between 2021/22 and 2022/23, from 4.7 million to 7.2 million. This means that 11% of people in the United Kingdom lived in food-insecure households in 2022/23, including 17% of all children (Francis-Devine, 2024).

Fig. 14

Premature mortality from NCDs has remained below EU and WHO European Region averages

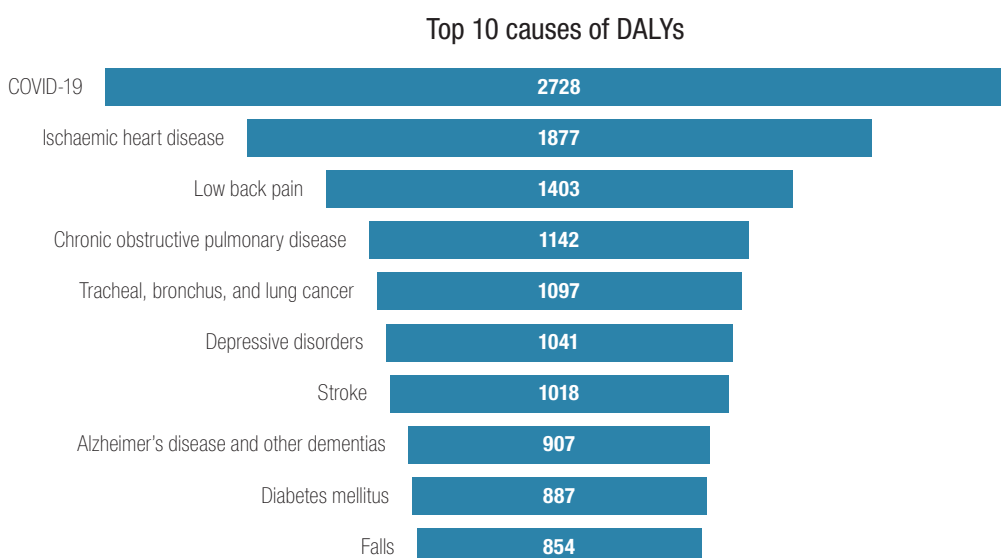


Source: WHO Regional Office for Europe, 2024b.

Note: Premature mortality among those aged 30–69 years from four major NCDs (cardiovascular diseases, cancers, diabetes mellitus and chronic respiratory diseases).

Fig. 15

COVID-19 was the leading cause of ill-health in the United Kingdom in 2021



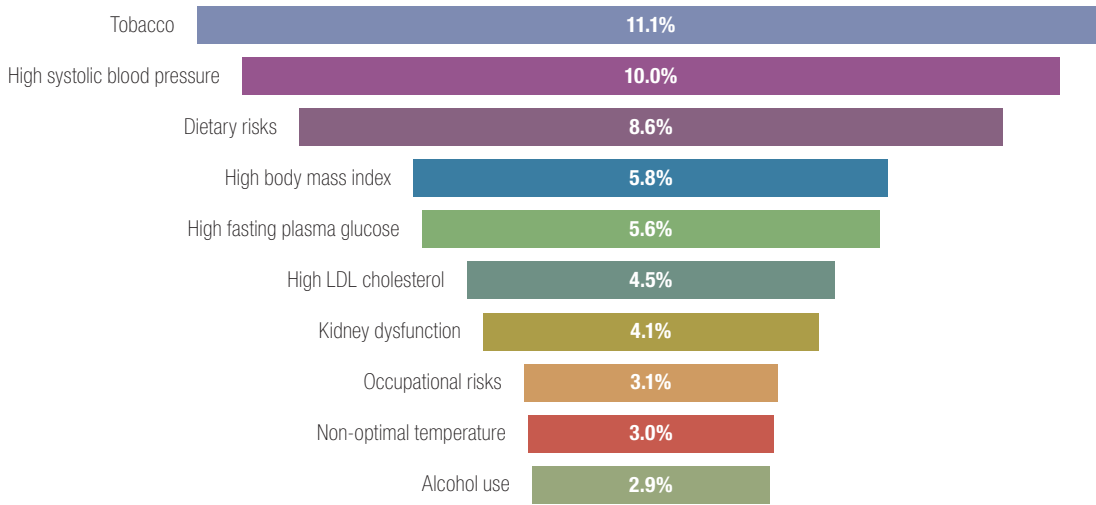
Source: IHME, 2024.

Note: Top 10 causes of DALYs per 100,000 population for both sexes and all ages. Data refer to 2021.

Fig. 16

Tobacco use, high blood pressure and poor diet are the top three risk factors resulting in death

Top 10 risk factors as a share of all deaths



Source: IHME, 2024.

Note: Percentage of all deaths attributable to risk factors for both sexes and all ages.

In England there is a 19-year gap in healthy life expectancy between the most and least deprived areas of the country, with people in the most deprived communities getting multiple long-term health conditions 10 to 15 years earlier than those in the least deprived communities, as well as spending more years in ill-health and dying sooner (Office for Health Improvement and Disparities, 2022). A policy initiative to address health inequalities across the United Kingdom is described in Box 3.

Box 3

The Core20Plus5 policy aims to reduce health inequalities

To address health inequalities, the government in the United Kingdom has introduced the 'Core20PLUS5' policy (NHS England, 2021), which focuses action on the most deprived 20% of the national population (as identified by the national Index of Multiple Deprivation), plus groups experiencing poorer than average health access, experience and/or outcomes (identified through comparisons of local system data). The five clinical areas of focus for action include:

- continuity of care in maternity services,
- annual health checks for those living with severe mental illness,
- strengthening chronic obstructive pulmonary disease (COPD) management, with a focus on COVID-19, flu and pneumonia vaccination uptake,
- early cancer diagnosis, and
- proactive hypertension and high cholesterol case-finding.

A National Inequalities Improvement Dashboard has been developed to monitor progress (NHS England, 2021).

Source: Office for Health Improvement and Disparities, 2022.

5 SPOTLIGHT ON HEALTH WORKFORCE TRENDS

Staffing levels and health workforce trends are a concern

The number of physicians per 100 000 population increased from 271 to 317 between 2013 and 2022, but this remains below the WHO European Region average (Fig. 17). Moreover, the number of medical graduates only increased slightly in this time period, from 8450 to 9140, which was very low in international comparison. The rate of nurses increased between 2013 and 2022, now surpassing the average in the WHO European Region. While there are about as many female as male doctors, 88.6% of nurses in 2018 were female, highlighting the importance of gender considerations in recruitment and retention.

The share of physicians who are generalist medical practitioners remained fairly stable between 2013 and 2021

Despite an ongoing policy agenda to shift care from hospitals to the community, the proportion of physicians who were generalist medical practitioners in 2021 was, at 20.4%, relatively modest and a slight decrease from the level in 2013 (Fig. 18). In England, while an increase in the total count of fully qualified GPs was found in an analysis covering 2015 to 2022, the average number of qualified GP full-time equivalents per 100 000 population fell from 53 to 45, representing a 15% fall (Pettigrew et al., 2024).

The United Kingdom is reliant on clinicians trained abroad

The health workforce is not ageing as rapidly in the United Kingdom as elsewhere in Europe, but this is largely due to a reliance on foreign-trained clinicians. The proportion of doctors aged 55 years or over in the United Kingdom was lower in 2022 (12.5%) than in 2012 (13.2%), while the proportion of nurses aged 55 years or over in 2019 was 23.4% (Fig. 19).

The United Kingdom has a relatively high proportion of both doctors and nurses trained abroad or in an unknown place of training, amounting to 37.5% for doctors and 18.7% for nurses (Fig. 20). This reflects in part a recent sharp rise in the migration of doctors from outside the European Economic Area (EEA) following legislative changes in 2021. For migrants from the EEA, however, English tests introduced in 2016, new revalidation processes and Brexit contributed to a sharp decline of nurses registering to practise in the United Kingdom (Anderson et al., 2022).

In 2022, half of all doctors registering in the United Kingdom had trained abroad (Migration Observatory, 2023). There are some concerns about recruitment from lower- and middle-income countries on the WHO Health Workforce Support and Safeguards list from which active recruitment is discouraged by WHO. The United Kingdom has a long history of periods of elevated migration in response to NHS shortages. The period prior to 2015 saw increased recruitment from the EEA (Dayan & Palmer, 2019).

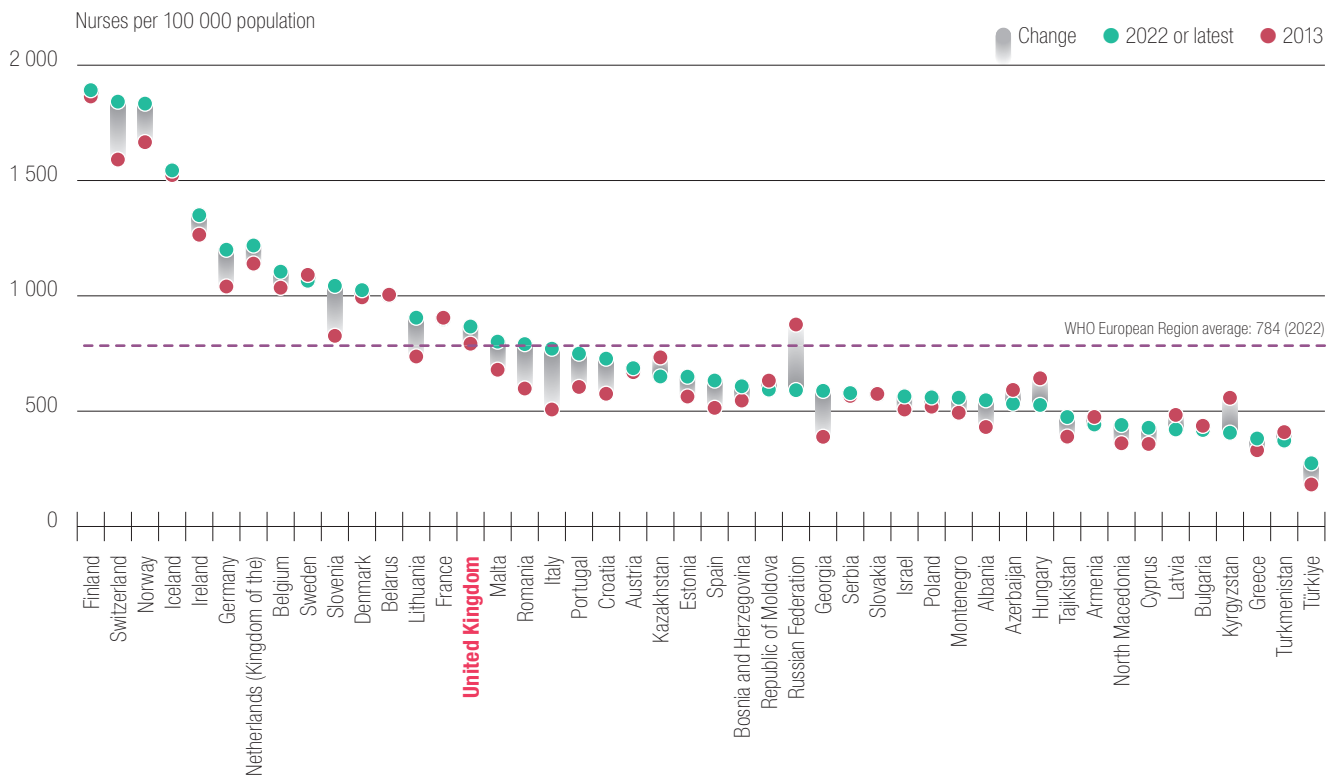
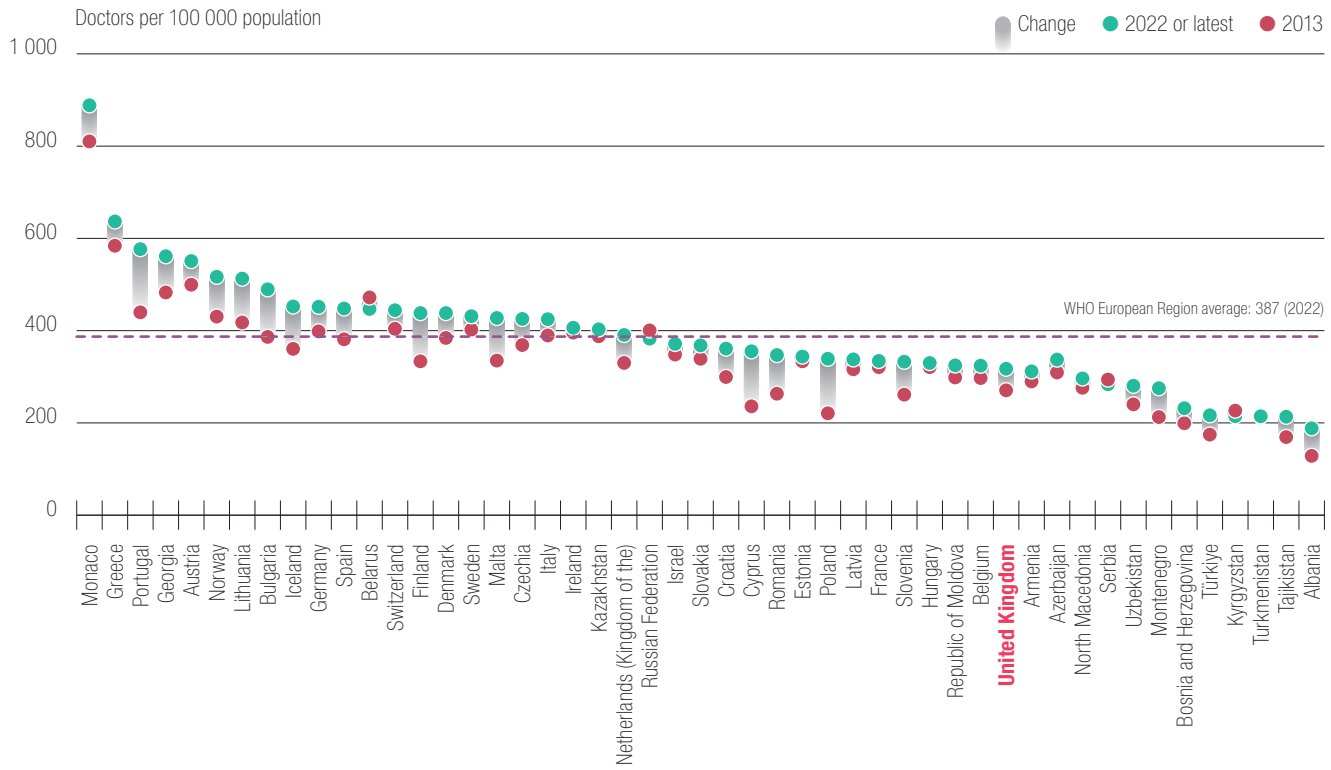
At the same time the United Kingdom is a source country for health workforce migration

While no national dataset exists, the number of applicants for certificates from the nursing regulator required to leave and practise abroad has risen from around 3000 a year in 2018/19 and 2019/20 to 12 000 in 2022/23, most of whom were originally trained outside the United Kingdom (Bazeer et al., 2024). This is yet to translate into significant changes in the flow of staff out of the United Kingdom health system.

Maintaining an adequate health workforce in the United Kingdom is faced with several challenges. Changing career behaviours and expectations are reflected in a doubling of doctors pausing their training between 2011/12 and 2020/21 (Nuffield Trust, 2023b). Repeated industrial action between 2022 and 2024, unprecedented in the health service's history, suggests that pay policies may be struggling to maintain competitiveness and attractiveness at a time of global shortages of medical staff and high inflation (Rigby et al., 2023; Jeurissen et al., 2024).

Fig. 17

The number of doctors per 100 000 population in the United Kingdom has increased

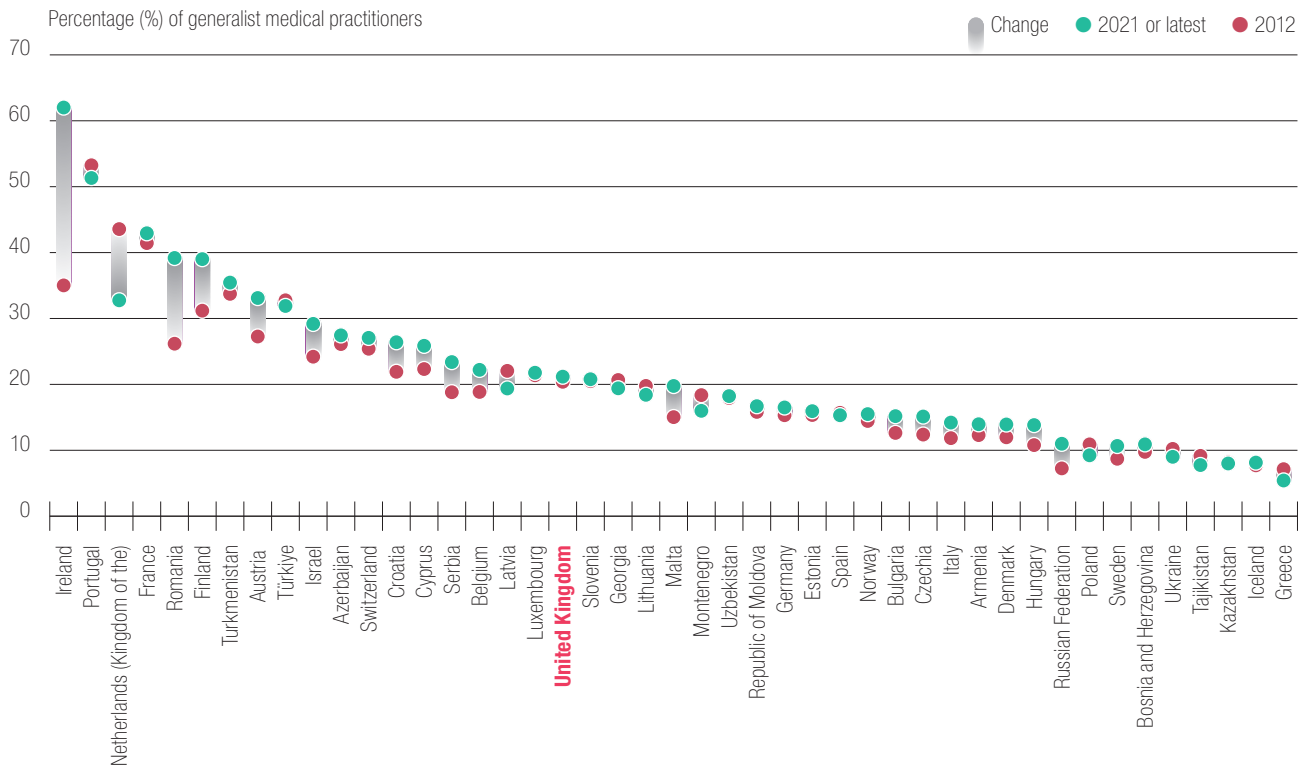


Source: WHO, 2024d.

Note: The methods for data collection of the number of doctors in England changed in 2015, which makes it challenging to compare numbers in 2013 with those in 2022. The number of nurses plotted for Austria has to be treated with caution, due to breaks in the time series and switching between "licensed to practise" and "practising" workforce numbers.

Fig. 18

The percentage of doctors who are generalist medical practitioners slightly decreased between 2012 and 2021

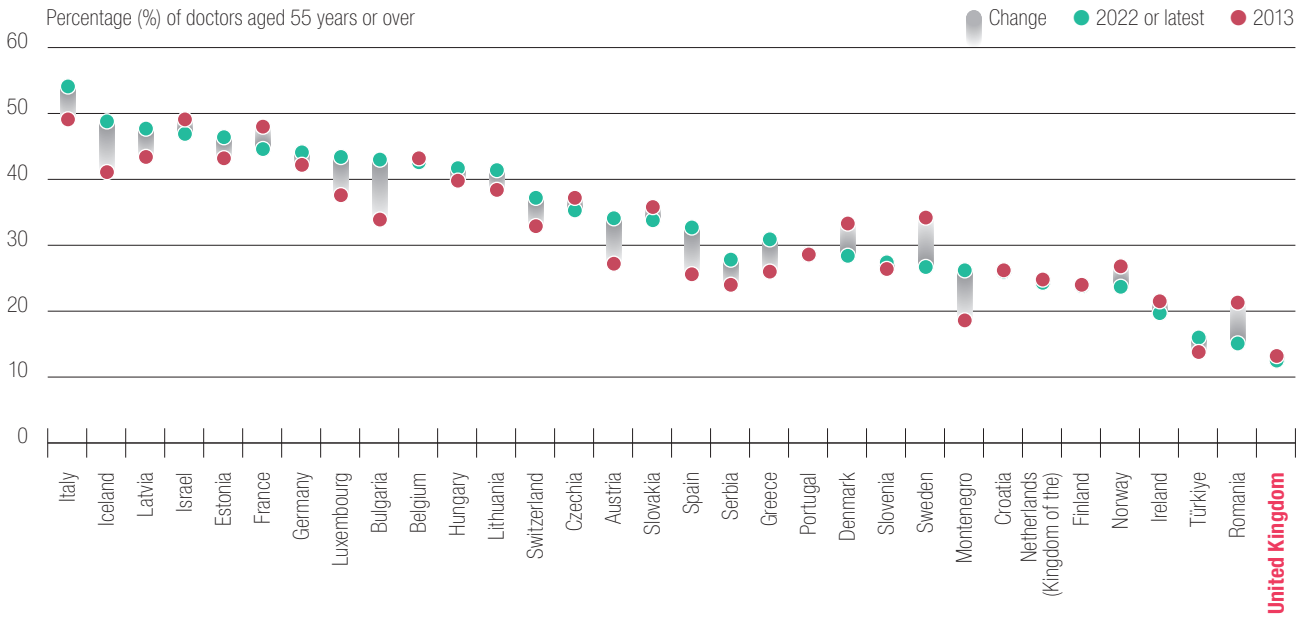


Source: WHO Regional Office for Europe, 2024c.

Note: Generalist medical practitioners (ISCO-08 code: 2211) are physicians who do not limit their practice to certain disease categories or methods of treatment and may assume responsibility for the provision of continuing and comprehensive medical care to individuals, families and communities. They include general practitioners, district medical doctors, therapists, family medical practitioners, primary health care physicians, medical doctors (general), medical officers (general), and medical interns or residents specializing in general practice or without any area of specialization yet. Although in some countries “general practice” and “family medicine” may be considered as medical specializations, these occupations are also classified here. The data for Ireland should be treated with caution due to a break in series.

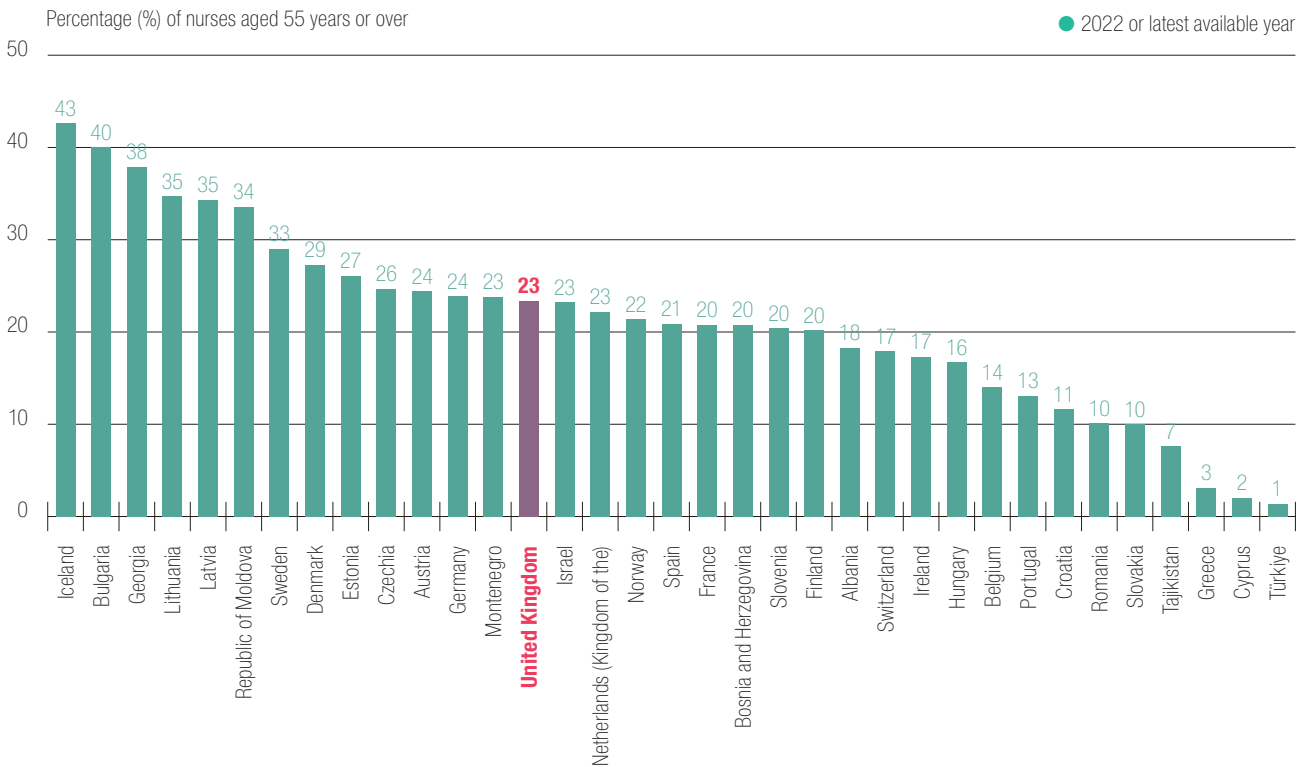
Fig. 19

The percentage of doctors aged 55 years and over in the United Kingdom is very low, while just under 25% of nurses were aged 55 years or over in 2019.



Source: WHO, 2024d.

Note: Data for the United Kingdom refer to 2019.



Source: WHO, 2024d.

Fig. 20

More than one in three doctors and almost one in five nurses working in the United Kingdom were trained abroad



Source: WHO, 2024d.

6 EUROPEAN PROGRAMME OF WORK (EPW)

Moving towards universal health coverage

All four countries of the United Kingdom provide universal population coverage to permanent residents through public sector health services funded from general taxation. Undocumented migrants and temporary visitors receive coverage for emergency care and certain infectious diseases but are charged for planned treatment.

Over the past decade waiting times have reduced the level of access to elective care, urgent care and primary care appointments, across the United Kingdom. These difficulties were exacerbated by the COVID-19 pandemic, and in 2023 there was an increase in people purchasing private care out of pocket.

Protecting against health emergencies

A 2022 Resilience Framework sets out an agenda for improving preparedness and readiness across public services, including by strengthening Local Resilience Forums, establishing a Resilience Directorate in central government, and trying to identify investment priorities (United Kingdom Government, 2023). There is no comparable national exercise specifically for health or infectious disease preparation.

The United Kingdom-wide COVID-19 inquiry, which works on a statutory basis with the power to compel witnesses, has a remit to learn lessons across preparedness, resilience and the response of the health and social care sectors. Interim reports are anticipated from 2024 to 2026.

Promoting health and well-being

The previous and current governments have committed to passing a Tobacco and Vapes Act, which is currently passing through the legislative process. This would prohibit the sale of tobacco products to people born on or after 1 January 2009, introduce new fines for selling vaping products to under-18-year-olds, and gradually phase out the sale of tobacco products. Scotland implemented a minimum price for alcohol per unit in 2018. This was extended in 2024, and the minimum price increased by 30% to £0.65 per 10ml of alcohol. Evaluation has shown strong evidence of a (3%) fall in total alcohol sales in the off-trade following MUP implementation, as well as an (estimated) aversion of (156) deaths and (411) hospital admissions (a year) wholly attributable to alcohol (Public Health Scotland, 2023; Wyper et al., 2023). Reductions in consumption were greater among heavier drinkers than lighter drinkers, except for the heaviest 5% of male drinkers (Rehm et al., 2022).

COUNTRY SUMMARY DATA

	United Kingdom	WHO European Region	European Union
Life expectancy at birth, both sexes combined (years)	80.5 (2020)	78.2 ^a	79.9 ^a
Estimated maternal mortality per 100 000 live births (2020)	9.8	12.6	6.4
Estimated infant mortality per 1 000 live births (2021)	3.7	6.3	3.2
Population size, in millions (2020)	67.5	929.1	512.7
GDP per capita, PPP\$ (2021)	49 675	38 936	48 615
Poverty rate at national poverty lines (% of population)	18.6 (2017)	14.9 (2018)	17.0 (2018)

Sources: WHO Regional Office for Europe, 2024b;

^a Eurostat, 2024b, for EU/EEA countries, Albania, Montenegro, North Macedonia, Serbia, Armenia, Azerbaijan, Georgia and Türkiye.

Note: Life expectancy averages refer to latest available years.

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WHO Regional Office for Europe

WHO is the authority responsible for public health within the United Nations system. The WHO Regional Office for Europe (WHO/Europe) covers 53 countries, from the Atlantic to the Pacific oceans.

To support countries, WHO/Europe seeks to deliver a new vision for health, building a pan-European culture of health, where health and well-being goals guide public and private decision-making, and everyone can make healthy choices. WHO/Europe aims to inspire and support all its Member States to improve the health of their populations at all ages. WHO/Europe does this by providing a roadmap for the Region's future to better health; ensuring health security in the face of emergencies and other threats to health; empowering people and increasing health behaviour insights; supporting health transformation at all levels of health systems; and by leveraging strategic partnerships for better health.

European Programme of Work 'United Action for Better Health in Europe'

The European Programme of Work (EPW) sets out a vision of how the WHO Regional Office for Europe can better support countries in our region in meeting citizens' expectations about health.

The social, political, economic and health landscape in the WHO European Region is changing. United action for better health is the new vision that aims to support countries in these changing times. "United", because partnership is an ethical duty and essential for success, and "action" because countries have stressed their wish to see WHO move from the "what" to the "how", exchanging knowledge to solve real problems. The WHO European Region's solidarity is a precious asset to be nurtured and preserved and, through the EPW, WHO/Europe supports countries as they work together to serve their citizens, learning from their challenges and successes.

The European Observatory on Health Systems and Policies

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making so that countries can take more informed decisions to improve the health of their populations. It brings together a wide range of policy-makers, academics and practitioners, drawing on their knowledge and experience to offer comprehensive and rigorous analysis of health systems in Europe. The Observatory is a partnership hosted by WHO/Europe. Partners include the governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Spain, Sweden, Switzerland, the United Kingdom, and the Veneto Region of Italy (with Agenas); the European Commission; the French National Union of Health Insurance Funds (UNCAM), the Health Foundation; the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM). The Observatory is based in Brussels with hubs in London (at LSE and LSHTM) and at the Berlin University of Technology.