2026 Election Policy Insights: Health

This Policy Insights piece was published by the University of Glasgow Centre for Public Policy on 29 May 2026. If you would like more information, contact public-policy@glasgow.ac.uk.

Policy Insights by Professor Sara Macdonald

In the recent Scottish parliamentary elections, health proved a key priority. As a devolved issue, health is always high on the political agenda in Scotland, but in this election season it has been singularly important. This policy insight will reflect on the health challenges facing Scotland and what the major political parties are saying, and critically not saying, about their plans for the nation's health.

Scotland's health: An unprecedented crisis

It is impossible to deny the parlous state of Scotland's health. Life expectancy, although back to pre-pandemic levels, remains the lowest in the UK with significant inequalities between affluent and deprived communities. Men in our most affluent communities can expect to live 13.5 years longer than their most deprived counterparts; the figure for women is 10 years. Recent figures show that in Scotland healthy life expectancy, (the number of years one can expect the live a healthy life), has reduced since 2016 and is now the worst in Europe. Again, there are significant disparities between communities. Women in the most deprived communities can expect to live 26.7 more years in poor health than their affluent counterparts. This gap for men is 25.6 years. These stark figures matter not only for the individuals living with illness, or for the families of those dying prematurely. They have implications for public services and for the country's overall wellbeing and prosperity. Many of the explanations for such a poor health picture lie outside of the health service – ingrained poverty, unemployment, poor housing. All are significant contributors, but their impact is felt within the health service, with many commentators questioning whether, or how, the NHS can survive.

Existing cracks in the health system across the UK were exposed by Covid. The legacy of pandemic pressures, alongside a raft of additional demands, has resulted in a 'deep crisis' in the NHS. Unprecedented waiting lists for elective procedures, long waiting times in A&E, difficulties accessing GP appointments, and staff shortages have contributed to reduced public confidence. Such internal system-specific strains, combined with broader, persistent problems like deep-rooted health inequalities and on-going issues with provision and funding of social care, point to the 2026 Scottish parliamentary election as pivotal for the nation's health.

The political response: increase supply

Far from avoiding the issues, all the major political parties seem alive to the problems and converge around the diagnosis. The breadth of the health problems is acknowledged by most mainstream political parties. The SNP, Labour, Greens and Liberal Democrats all use language that hints at the salience. Yet the solutions offered are typically inward-looking, focusing in on what could be termed firefighting measures to bolster front line services and alleviate further crisis. Cutting waiting times, increasing GP appointments, creating treatment centres to improve capacity, rolling out GP walk-in centres and similar mental health facilities all feature prominently. There is a disappointing sameness to the flagship policies detailed across party manifestos. While increasing supply and improving access may initially attract votes, failure to grapple with the source of the growing demand risks any policy changes proving unsustainable.

Demand drivers: Multiple long-term conditions

According to the Academy of Medical sciences, Multimorbidity, often referred to as Multiple Long-Term Conditions (MLTC), is one of the biggest challenges facing health systems worldwide. Scotland is no exception, and our overall health landscape makes the MLTC challenge especially relevant. MLTCs impact individuals, families, communities, the health and social care system and society. Yet, discussion of MLTCs was noticeably absent from the manifesto commitments offered by the major parties. Half of all Scots live with at least one chronic health condition and for many this curtails or limits everyday activities. Chronic illness is defined as an illness that lasts for a year or more and involves self-management. It can include both

physical and mental health conditions. Common conditions include diabetes, asthma, chronic obstructive pulmonary disease (COPD), arthritis and other rheumatological conditions, pain, fatigue, depression and anxiety. Those living with MLTC typically live with two or more conditions. Precise estimates of the prevalence of MLTCs vary quite considerably but suggest between 20-40% of the population. Of course, MLTC is associated with ageing, and as people become older, they are more likely to accrue conditions. It is, though, not confined to older populations. Incidence in under-65s is increasing and because there are more under-65s across the population, the greatest burden of MLTC is in the under 65 population. For those living in areas experiencing persistent socioeconomic disadvantage, MLTC begins at least 10-15 years earlier, and MLTCs are more common in women and some ethnic minority groups.

People living with multimorbidity face significantly poorer health outcomes than those with a single condition. They are more likely to die prematurely, be admitted to hospital in an emergency and spend longer times in hospital after admission. In primary care the higher burden of MLTC means that a large proportion of consultations will involve MLTC often in combination with complex social problems. Additionally, MLTCs result in an overall lower health-related quality of life and poorer physical function. Mental health is also impacted and as physical conditions accrue rates of depression rise, and this is especially marked in areas of deprivation. In short, MLTCs result in more health care use than single conditions.

Yet most health systems - including Scotland's - are sub-optimal when it comes to MLTCs. Healthcare tends to be organised around individual illness specialities, meaning that those living with MLTCs often experience the health system as fragmented and uncoordinated. Organising care in this way is inefficient for healthcare systems and patients alike, often leading to more treatment burden in those living with MLTC. Treatment burden is a term used to describe the 'work' that people must do to manage their illnesses including lifestyle changes, attending appointments and managing medications. Yet research evidence on how best to manage MLTCs is scarce. Showing positive effects of interventions is difficult perhaps because treating MLTCs require more intense and prolonged care that also accounts for social complexity.

It is important to emphasise that MLTCs are not socially neutral. Those living in our most disadvantaged communities are four times more like to suffer MLTCs and MLTCs intersect with the wider social determinants of health cumulatively. Someone with MLTC living in a disadvantaged community can expect to have eight fewer healthy life years on average than their more affluent counterparts. People from disadvantaged communities often experience health services differently, face significant barriers. Trusted relationships with healthcare professionals can be compromised.

It is important to recognise that the MLTC problem has not gone entirely unnoticed. During the last parliament, the Scottish Government introduced steps to tackle the challenge of long-term conditions and MLTCs, with the launch of the new Long Term Conditions Framework. Responding directly to population need, where more than a third of Scotland's population live with at least one long term condition, and many have several, the Framework aims to adopt a more radical approach to how people living with illness in Scotland are supported. Rather than individualised, single-condition treatment plans, the Framework firstly recognises that there are many similarities across the experience of long-term conditions and that some of the solutions, principally person-centred care, have the potential to improve outcomes. The Framework acknowledges that rising MLTCs, particularly in the context of deprivation and in those under-65, has uncovered limits in the current organisation of the health system. Additionally, the Framework hopes to positively impact health inequalities and the burden of MLTCs on the NHS.

The Framework proposes more person-centred care that is better coordinated, importantly bringing together not only NHS services, but also social care and third sector support services. Within the framework, those living with MLTCs can expect more support to effectively manage their conditions themselves and have that support closer to home with responses that underline the importance of prevention. Shifting care to a model that emphasises individual needs beyond diagnostic labels may not seem radical, but it has the potential to represent a seismic shift in health service delivery.

Consultation on the Framework, which closed in July 2025, received responses from more than 350 individuals and organisations across Scotland. Although there was

broad support for the move away from siloed, single-disease working towards a more joined up service, some third sector organisations expressed concerned that the plans risk reducing skilled specialist approaches. Undoubtedly, a balance is required. However, there is an urgent requirement to provide services that equitably respond to need and seek to mitigate glaring inequalities in the experience of health and the response of the system. This will certainly require us to reconsider our national approach to social care, as well as to provide financial support to third-sector partners, many of whom have seen budgets cut over the last decade or more. Commitments to prevention and early intervention must be welcomed, but the commitments must be followed by appropriate investment.

The cracks exposed by the pandemic will not simply disappear with on-paper commitments to service change, and the Framework fails to fully consider the context of on-going workforce pressures, and wider social challenges, such as welfare and housing. Though the framework is a welcome move towards the recognition that longer-term planning rather than crisis driven management is needed and acknowledging that the experience of MLTCs is shaped by the wider social determinants of health.

The summary of the consultation was published in October 2025, and the Framework launch was originally planned for publication in March 2026 before being delayed. The future of the Framework will depend on the election results and the incoming government, but the promise of a thorough review of our national approach to MLTC can only be seen as constructive.

Author

Professor Sara Macdonald is Professor of Primary Care and Health Science in the School of Health & Wellbeing at the University of Glasgow. Sara's recent work has focused on the lived experience of MLTCs, mitigating health inequalities within communities and community-based approaches to improve health.

Policy Insights

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