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National Health Service: 70th Anniversary

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Summary

This Briefing has been produced to mark the 70th anniversary of the inauguration of the National Health Service on 5 July 1948. The Briefing provides a broad history of the NHS since its creation. It focuses on some of the key structural reforms made to the service and provides an overview of the policy approach of successive governments. The final section looks at the history of the NHS from a statistical perspective. It presents data on the cost of the NHS, measures of its size, and considers several key performance indicators.

On 5 July 1948, the Health Secretary, Aneurin Bevan, launched the NHS at Park Hospital in Manchester. At its inauguration, it was financed almost entirely from central taxation. Everyone was eligible for care, and it was to be free at the point of use. However, some charges have subsequently been introduced, such as those for prescriptions.

At its inception, the new service was based on a tripartite system of administration, with hospitals, general practice and local health authorities run separately. During the 1970s a major reorganisation of the NHS took place, and this system was replaced. Regional authorities were established and became responsible for all three parts of the NHS. Further reform has since taken place. However, when devolution took effect in 1999, and certain powers were transferred from the UK Westminster Parliament to the Scottish Parliament, Welsh Assembly, and the Northern Ireland Assembly, health became a largely devolved matter. This has led to a greater divergence of policy than previously between the different countries in the UK.

The overall cost of the NHS has grown faster than the wider economy. Since its inception, NHS expenditure has risen more than tenfold in real terms and more than doubled as a percentage of Gross Domestic Product. Data on the NHS workforce also illustrates its growth, with one estimate suggesting that it is the world's fifth largest employer. Since inauguration, nurse and general practitioner numbers have more than doubled, and consultant numbers risen more than tenfold. There is also a range of possible indicators of performance for the NHS. Using high-level health outcomes such as infant mortality and life expectancy, the last 70 years have seen significant improvements. Patient experience targets and customer satisfaction statistics show a more mixed picture, but this is only measurable on more recent data.

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26 June 2018

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1. Healthcare Provision Before the NHS

There has been some form of state-funded provision of health and social care in England for over 400 years.[1] In 1601, under Queen Elizabeth I, the first Poor Law established almshouses to care for the poor and sick.[2] In 1834, the Poor Law Amendment Act established a 'Poor Law Commission', which was run by government-appointed commissioners and a secretary.[3] In the localities about 600 boards of poor law guardians, elected by the ratepayers, were set up. Each board was responsible for a workhouse. These were established to provide accommodation for the poor, orphans and elderly. Under the new system, future support was contingent on the poor entering a workhouse.

By the 20th century, public health services were provided through an unevenly distributed and decentralised system of charitable voluntary hospitals, and the workhouses and hospitals administered under the poor law system.[4] In contrast, the developing family doctor service was funded through insurance schemes.[5] In 1911, the Liberal Government introduced legislation which established a scheme that provided insurance to low income workers. The National Insurance Act 1911 covered all manual workers between the ages of 16 and 70 years-old, and non-manual workers earning less than £160 a year. Participants could choose a general practitioner (GP) from a 'panel' of local doctors who had agreed to take part in the scheme. It only extended to the employee, not his or her family, although there was provision for maternity benefit for dependent wives.

In 1919, the Ministry of Health was created to improve public health and to bring together the medical and public health functions of central government.[6] It was also responsible for coordinating and supervising local health services in England and Wales. Under the provisions of the Local Government Act 1929, responsibility for the poor law hospitals, which had grown as appendages to the workhouses, were transferred to local authorities, enabling them to provide hospital and health services.[7] The hospitals were only available to local ratepayers.[8] The local authorities also

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[1] Department for International Development Health Systems Resource Centre, *The History and the Development of the UK National Health Service 1948–1999*, July 1999, p 5; and Peter Hennessy, *Never Again: Britain 1945–51*, 1992, p 124.
[2] Almshouses were also known as poor houses. They were locally administered public institutions for the homeless and persons without means.
[3] Peter Hennessy, *Never Again: Britain 1945–51*, 1992, p 124; and UK Parliament website, 'Poor Law Reform', accessed 25 May 2018.
[4] National Archives, 'The Poor Law and Ministry of Health', accessed 25 May 2018; and Department for International Development Health Systems Resource Centre, *The History and the Development of the UK National Health Service 1948–1999*, July 1999, p 5.
[5] ibid; and Peter Hennessy, *Never Again: Britain 1945–51*, 1992, p 126.
[6] Tony White, *A Guide to the NHS*, 2010, p 74.
[7] National Archives, 'The Poor Law and Ministry of Health', accessed 25 May 2018; and Peter Hennessy, *Never Again: Britain 1945–51*, 1992, p 124.
[8] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 27.

provided maternity hospitals, hospitals for infectious diseases like scarlet fever and smallpox, as well as those for the elderly, mentally ill and mentally handicapped. According to the medical historian, Geoffrey Rivett, the standard varied widely, depending on the attitude of the individual council.[9]

In 1939, in response to the likelihood of imminent war, the Government, led by Neville Chamberlain, established the Emergency Medical Service to coordinate treatment.[10] All the various types of hospitals were registered and run centrally to anticipate the large numbers of casualties. The Ministry of Health had the power to direct voluntary and local authority hospitals.

2. Establishment of the NHS

2.1 Proposals for Reform

Dawson Report (1920)

In 1920, the *Interim Report* of the Consultative Council on Medical and Allied Services was published, recommending the regionalisation of healthcare.[11] The document, known as the Dawson Report after the Council's chairman, royal physician Lord Dawson, laid out a structure a health service might take. It suggested that GPs should be accessible, attend patients at home or in the surgery, carry out treatment within their competence, have a role in antenatal supervision and obtain specialist help when it was needed.[12] It also advocated nursing to be based with the doctor in the primary health centres. The Council did not produce a final report and its recommendations were not implemented by the Government.[13]

Beveridge Report (1942)

In June 1941, Sir William Beveridge was appointed by the Coalition Government to chair an inter-departmental committee to examine Britain's social security schemes. The Beveridge Report was published in 1942. It proposed a "social service state" based on three services, which it identified as necessary pre-requisites to social security.[14] They were: family allowances, full employment, and a health service. The report advocated that as part of

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[9] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 27.
[10] National Archives, 'The Poor Law and Ministry of Health', accessed 25 May 2018; and Department for International Development Health Systems Resource Centre, *The History and the Development of the UK National Health Service 1948–1999*, July 1999, p 5.
[11] Ministry of Health, *Interim Report on the Future Provision of Medical and Allied* Services, 1920, Cm 693; and Marvin Rintala, *Creating the National Health Service: Aneurin Bevan and the Medical Lords*, 2003, p 78.
[12] Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*, 1998, p 1.
[13] Marvin Rintala, *Creating the National Health Service: Aneurin Bevan and the Medical Lords*, 2003, p 78.
[14] Sir William Beveridge, *Social Insurance and Allied Services*, November 1942, Cm 6404; and House of Commons Library, *Selected Highlights in the History of the National Health Service*, 12 November 2008, p 5.

its plan to provide social security:

> Medical treatment covering all requirements will be provided for all citizens by a national health service organised under the health departments and post-medical rehabilitation treatment will be provided for all persons capable of profiting by it.[15]

However, in 1943, the Coalition Government refused to commit itself to the Beveridge Report.[16]

A National Health Service White Paper (1944)

In 1944, the Coalition Government published the white paper, *A National Health Service*.[17] It was based on the twin principles that the service should be comprehensive and that it should be free. It proposed that under the supervision of the Ministry of Health, joint regional boards (combining the counties and country boroughs) would plan both primary and secondary care.[18] They would have directly administered the hospitals, whilst local authorities would have employed under contract most GPs. Voluntary hospitals would have retained their independence under the provisions. Each tier of government was to have a professional advisory committee. In addition, a central medical board, consisting mainly of doctors, would have acted as the ultimate 'employer' of GPs. The board would have had the power to refuse a GP permission to set up in a location already adequately serviced.[19]

2.2 National Health Service Act 1946

In July 1945, the Labour Party won the first general election held after the Second World War. Aneurin Bevan was appointed Minister of Health, and shortly after his appointment he instructed officials to prepare a healthcare nationalisation plan, with a view to having a bill ready to introduce in Parliament by the spring of 1946.[20] Bevan proposed a tripartite system of administration across public health, with local authority health services, hospitals and independent-contractor services, including GPs, dentists, pharmacists and ophthalmologists, run separately.[21] Hospitals in England and Wales were to be nationalised and organised under regional hospital

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[15] Sir William Beveridge, *Social Insurance and Allied Services*, November 1942, Cm 6404, p 11.
[16] Marvin Rintala, *Creating the National Health Service: Aneurin Bevan and the Medical Lords*, 2003, p 16.
[17] Ministry of Health and Department of Health for Scotland, *A National Health Service*, February 1944, Cm 6502.
[18] Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, p 181; and Peter Hennessy, *Never Again: Britain 1945–51*, 1992, pp 134–5.
[19] Peter Hennessy, *Never Again: Britain 1945–51*, 1992, p 135.
[20] ibid, p 138.
[21] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, pp 27–8; and National Archives, 'Beveridge and Bevan', accessed 25 May 2018.

boards,[22] and there would be a full-time salaried general practitioner service. Care was to be free at the point of use.

The National Health Service Bill was introduced in the House of Commons in March 1946, and received royal assent on 6 November 1946. During the second reading debate in the House of Commons, Bevan said:

> [I]t ought to have been a pride to hon Members in all parts of the House that Great Britain is able to embark upon an ambitious scheme of this proportion […] I myself, […] take very great pride and great pleasure in being able to introduce a Bill of this comprehensiveness and value. I believe it will lift the shadow from millions of homes. It will keep very many people alive who might otherwise be dead. It will relieve suffering. It will produce higher standards for the medical profession.[23]

The publication of the Bill initiated a period of conflict between the Government and the British Medical Association (BMA).[24] The association was resistant to the transfer of practitioners to state salaries and fought to maintain remuneration according to numbers of patients. Following negotiations between the Bill's enactment in November 1946 and the NHS's inauguration in July 1948, the Government conceded that a full-time salaried service would not be implemented, and that the salary component of GPs' remuneration would be optional.

Broadly similar structures were agreed for Scotland and Northern Ireland under the provisions of the National Health Service (Scotland) Act 1947 and Health Services Act (Northern Ireland) 1948 respectively.[25] Common policies were implemented across the whole of the UK: with access to the NHS being free at the point of delivery (except for the subsequent introduction of prescription charges), and typically via a GP, who acted as 'gatekeeper' to specialist services.

The following sections, unless specified otherwise, focus on the NHS established in England and Wales, under the provisions of the National Health Service Act 1946.

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[22] Scotland and Northern Ireland also implemented these proposals, but Bevan was not responsible for health policy in either. It was under the remit of the Secretary of State for Scotland and the Health Minister at Stormont respectively.

[23] HC *Hansard*, 30 April 1946, col 63.

[24] National Archives, 'Policy and Inauguration', accessed 25 May 2018.

[25] Health Foundation and Nuffield Trust, *The Four Health Systems of the United Kingdom: How Do They Compare?*, April 2014, p 27.

2.3 Inauguration of the NHS

Principles of the NHS

The NHS was inaugurated on 5 July 1948. It was financed almost entirely from central taxation and the rich paid more than the poor for comparable benefits.[26] Everyone was eligible for care, even people temporarily resident or visiting the country. People could be referred to any hospital. Care was free at the point of use, although prescription charges and dental charges were subsequently introduced in the 1950s.

Administrative Structure

The new service was tripartite, with hospitals, general practice and local health authorities run separately.

- **State owned (nationalised) hospitals**
  The hospitals run by the charitable voluntary organisations and local government were brought together in a single system in which staff were salaried.[27] In England and Wales, organisation was based on 14 regional hospital boards. The teaching hospitals were directly responsible to the Ministry of Health. Consultants were permitted to continue to use 'pay beds' for private practice.[28]
- **Primary care services**
  General practitioners, dentists, opticians and pharmacists were self-employed under a contract for services from an executive council. GPs were the 'gatekeepers' to other health services, referring patients where appropriate to hospitals or specialist treatment, and prescribing medicine and drugs.[29] Executive councils received money directly from the Ministry of Health.
- **Community and domiciliary health services**
  Services such as home nurses, maternity clinics, public and environmental health, and health prevention and promotion continued to be run by elected local authorities.[30] Local authority health services were managed by a Medical Officer of Health.

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[26] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 29.
[27] ibid.
[28] National Archives, 'Policy and Inauguration', accessed 25 May 2018; Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, p 183; and Peter Hennessy, *Never Again: Britain 1945–51*, 1992, p 142.
[29] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 29; and Department for International Development Health Systems Resource Centre, *The History and the Development of the UK National Health Service 1948–1999*, July 1999, p 6.
[30] ibid.

3. Demand and Cost in the 1950s

3.1 Introduction of Charges

Within the first year of the creation of the NHS, concerns were expressed by members of the Labour Government's Cabinet about the cost of the service.[31] Between 1948 and 1951 debate was had about how to deal with the increasing cost of healthcare. During this period, NHS spending was outstripping the 1946 forecast of £134 million.[32] The cost of the NHS in the UK in 1949/50, its first full year of operation, was £447 million.[33] In 1950/51 the cost was £474 million.

Bevan argued that the cost was principally caused by the backlog of interwar ill-health and the need to rectify the long-term underfunding of health services.[34] Although some savings were made by cuts to hospital capital projects, the Treasury, under Stafford Cripps and then Hugh Gaitskell, believed that the NHS should introduce some charges. The National Health Service Amendment Act 1951 introduced charges for dental and ophthalmic care.

The Conservative Party won the general election in 1951, and introduced further charges for dentistry as well as prescription charges.[35]

3.2 Guillebaud Committee

In 1953, the Conservative Government appointed the independent Committee of Enquiry into the Working of the National Health Service.[36] It was chaired by the Cambridge economist, Claude Guillebaud, and was established to enquire into the cost of the National Health Service. The Committee published its report in 1956, and stated that it had found no opportunity for new sources of income or substantial reductions in the annual cost of the service.[37] The Committee found that in England and

[31] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 30; National Archives, 'Financial Crisis', accessed 25 May 2018.
[32] Figures listed in the Financial Memoranda appended to the National Health Service Bills; Charles Webster, *The Health Services Since the War*, 1988, vol I, p 133. During the debate in the House of Commons on the Financial Resolution for the National Health Service Bill, Major Guy Lloyd (Unionist MP for Renfrewshire Eastern) complained that the "estimate of its ultimate total cost" was "grossly inadequate" (HC Hansard, 2 May 1946, col 432).
[33] Emma Hawe and Lesley Cockcroft, *Office of Health Economics Guide to UK Health and Healthcare Statistics*, Office of Health Economics, October 2013, p 45. See section 8 of this Briefing for further information about the cost of the NHS since its inauguration.
[34] Peter Hennessy, *Never Again: Britain 1945–51*, 1992, p 417; Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, p 186; and National Archives, 'Financial Crisis', accessed 25 May 2018.
[35] National Archives, 'Financial Crisis', accessed 25 May 2018.
[36] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 191.
[37] Ministry of Health, *Report of the Committee of Enquiry into the Cost of the National Health Service*, January 1956, Cm 9663.

Wales, NHS expenditure per head had fallen in relative terms between 1948 and 1954; from 3.75 percent to 3.25 percent of Gross National Product (GNP). It also concluded that capital expenditure, which was 33 percent of pre-war levels, was too low. As a result, the Committee rejected proposals to: increase existing charges; introduce a hospital boarding charge; and to exclude from the NHS the 'non-central' ophthalmic and dental services.[38]

Following the Committee's conclusions, the Government did not at that time introduce cuts in NHS expenditure, and instead examined options to increase funding.[39] The National Insurance Act 1957 doubled the national insurance contribution, with the Government promising that funding would go to the NHS. Towards the end of 1960, the Cabinet debated and agreed on a further shilling increase in the national insurance contribution.

4. Expansion: National Hospital Plan

During the late 1950s and the 1960s, medical treatments were improving as more effective drugs were introduced.[40] For instance, the polio vaccine became available, and dialysis for chronic renal failure and chemotherapy for certain cancers were developed. However, according to Geoffrey Rivett and Rodney Lowe, Professor of Contemporary History at the University of Bristol, "the ill-sorted, ill-equipped and ill-distributed collection of hospitals", that the NHS had inherited from the poor law and voluntary sector, did not match the "skills of the consultants in the major specialities throughout the country".[41]

In 1962, the Minister of Health, Enoch Powell, published *A Hospital Plan for England and Wales*. The Plan set out a ten-year programme for hospital building.[42] Its objective was to guarantee access for both the medical profession and the public to the most modern and comprehensive facilities. Accordingly, 1,250 hospitals were to be closed, and at the cost of £500 million, 360 extended and 90 new ones built to provide a national network of 600 to 800-bed district general hospitals, each serving a catchment area of between 100,000 and 150,000 people. The plan specified 'norms'—the number of beds per 1,000 population served. In keeping with the Plan, the annual rate of investment in the NHS more than doubled over the following decade.[43] However, Lowe argues that despite this, neither the promised savings, nor the full complement of district general hospitals, had

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[38] Ministry of Health, *Report of the Committee of Enquiry into the Cost of the National Health Service*, January 1956, Cm 9663; and Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, p 193.
[39] National Archives, 'Conservative Rule', accessed 25 May 2018.
[40] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 31
[41] ibid; and Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, pp 192–3.
[42] Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, p 193.
[43] Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention*, 2010, p 55.

been achieved by the time of the Plan's abandonment in 1973.[44] Rivet concludes that it had "soon became clear" that the ten-year programme had "underestimated the cost and time it would take to build new hospitals".[45]

5. Reorganisation of the NHS

5.1 NHS Reorganisation

During the 1960s and early 1970s, debate was had on the need for organisational change to the three-part structure of the NHS. According to Emeritus Professor of Social Policy at the University of Bath, Rudolf Klein, there was consensus across the political parties that the original structure had "one fundamental inbuilt weakness": the administrative separation of hospitals, general practice and local authority health services. Klein argues that the "conventional wisdom" was that the NHS needed an "organisational fix".[46] The tripartite structure was eventually replaced with a unitary structure in 1974.

Porrit Report (1962)

In 1958, the medical profession established a committee to review the state of the medical services in Great Britain.[47] This committee, under the chairmanship of Sir Arthur Porrit, a former Olympic athlete and surgeon, completed its report in November 1962. The Committee concluded that requisite improvements to healthcare were unlikely to be attained without a reorganisation of the health service. The report recommended the assimilation under a single authority of all health services located in each natural area of administration. According to Geoffrey Rivet and the historian Charles Webster, this report was a catalyst to further debate on the reorganisation of the NHS.[48]

Proposals for Reform under the Labour Government

In 1964, the Labour Party won the general election. In 1967, the Minister for Health, Kenneth Robinson, began an examination of NHS administration, which resulted in the green paper, *Administrative Structure of the Medical and Related Services in England and Wales*. This document recommended the creation of about 50 area boards in a single organisational tier.[49]

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[44] Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, p 193. Focus instead turned to the reorganisation of the NHS.
[45] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 31.
[46] Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention*, 2010, p 66.
[47] Charles Webster, *The National Health Service: A Political History*, 2002, p 61.
[48] ibid; and Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 32.
[49] National Archives, 'Reform and Administrative Weakness', accessed 26 May 2018.

These would have taken responsibility for all health functions in each administrative area.

In 1968, Richard Crossman replaced Kenneth Robinson, becoming head of the new Department of Health and Social Security (DHSS). Crossman produced a further green paper, which addressed some of the criticisms of the earlier scheme through a return to a regional element of organisation.[50] Under Crossman's proposals, there would have been 90 local health authorities independent of local government, reporting to the DHSS through regional health councils. The geographic areas covered by the local health authorities would have corresponded with those of local government, which would have continued to be responsible for public health.

NHS Reorganisation (1974)

The Conservative Party won the June 1970 general election. Sir Keith Joseph was appointed Secretary of State for Social Services and was responsible for health policy.[51] Joseph produced his own proposals for reorganisation which were embodied in a white paper, published in August 1972.[52] These were subsequently incorporated in the National Health Service Reorganisation Act 1973. The Labour Party returned to power following the 1974 general election and implemented the measures.

As a result, a major reorganisation of the NHS took place in early 1974.[53] Regional authorities, covering all three parts of the NHS and incorporating the teaching hospitals, replaced the previous authorities.[54] A new tier of area health authorities (AHA) was established with boundaries largely coterminous with local authorities. Larger AHAs were also divided into districts to make them easier to manage.[55] The 14 regional health boards were executive agencies and were to act as a link between the DHSS and the AHAs. They became strategic planning authorities with operational authority delegated to the AHAs. Although coordination of contractor GP services and the planning of health centres became AHA responsibility in 1974, the day-to-day operation of these services remained unaffected.[56]

The 1974 reorganisation was followed by a royal commission, set up to investigate its effects.[57] The Commission, which reported in March 1979, criticised the reorganisation for introducing too many layers of management,

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[50] National Archives, '[Structural Reorganisation]', accessed 26 May 2018.
[51] ibid.
[52] HM Government, *National Health Service Reorganisation: England*, August 1972, Cm 5055.
[53] House of Commons Library, *Selected Highlights in the History of the National Health Service*, 12 November 2008, p 5.
[54] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 33.
[55] Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention*, 2010, p 69.
[56] Judith Allsop, *Health Policy and the NHS Towards 2000*, 1995, p 155.
[57] ibid, p 54.

and for the unpreparedness of the existing management to implement the change.[58] The result, the Commission believed, was excessive bureaucracy and an enormous amount of labour for disproportionately little effect.

5.2 Professional Development

The 1960s saw a series of developments in the structure and management of the professions working in healthcare.[59]

Negotiations between the Government and GPs' leaders resulted in the 1965 'GPs' Charter'. This was a new contract that provided financial incentives for practice development, and recognition of general practice as a speciality with post-graduate training.[60] Geoffrey Rivet argues that the Charter encouraged the formation of primary healthcare teams, new group practice premises and an increase in the number of health centres.[61]

The organisation of hospital nursing services was changed as a result of the 1967 'Salmon Report' on senior nursing staff structure.[62] The report set out recommendations for the development of a senior nursing staff structure and raised the status of the profession in hospital management.

Also published in 1967 was the first 'Cogwheel Report' of the Joint Working Party on the Organisation of Medical Work in Hospitals in England and Wales, appointed by the Ministry of Health in 1966.[63] It recommended that doctors become more deeply involved in medical management and proposed the formation of medical divisions along clinical lines to encourage better methods of medical practice and financial management.[64] Consultants were encouraged to group into divisions of related specialities and to involve themselves in the planning of services, including the coordination of hospital work with community services.

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[58] Royal Commission on the National Health Service, *Report*, July 1979, Cm 7615.
[59] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, pp 31–2.
[60] ibid; and Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, pp 199–200.
[61] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 32.
[62] ibid; and NHS Leadership Academy, 'Salmon Report 1967', accessed 25 May 2018.
[63] Ministry of Health, *First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals*, 1967.
[64] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 32; and Department for International Development Health Systems Resource Centre, *The History and the Development of the UK National Health Service 1948–1999*, July 1999, p 8.

6. NHS under the Conservative Government (1979–1997)

6.1 General Management

In 1979, the Conservative Party returned to power with a manifesto commitment to "simplify and decentralise the [NHS] and cut back bureaucracy".[65] One of the Government's first reforms was to abolish the area tier of management in 1982, so that there were 192 district health authorities directly responsible to the regional health authorities.[66]

In 1983, Roy Griffiths, a director of Sainsbury's, published his report on the management of the NHS. His report concluded that "institutionalised stagnation" was holding the service back.[67] Griffiths recommended that general managers be appointed at every level of the service. General management was introduced in 1984, encouraging: one individual at every level of an organisation to be responsible and accountable for planning and implementing decisions; greater emphasis on clear leadership; and more involvement for doctors in budget decisions.[68] The reform was met with concerns from the BMA. It worried that clinical freedom would be compromised if these managers were not doctors, and from the Royal College of Nursing. It was concerned that nurses would lose their influence on health boards.[69]

6.2 'Internal Market'

In 1988, the Government announced that it would be reviewing the NHS.[70] In 1989, the white paper, *Working for Patients*, was published.[71] It set out proposals for the introduction of an 'internal market', through the separation of 'providing services' from 'purchasers' within the NHS.[72] These measures were passed into law under the provisions of the National Health Service and Community Care Act 1990.

After the establishment of the 'internal market', 'purchasers' (health authorities and some family doctors) were given budgets to buy healthcare from 'providers' (acute hospitals, organisations providing care for the

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[65] Margaret Thatcher Foundation, 'Conservative General Election Manifesto', April 1979.
[66] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 34.
[67] Judith Allsop, *Health Policy and the NHS Towards 2000*, 1995, p 155.
[68] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 34.
[69] Health Service Journal, 'Five Days that Shook the NHS', *Health Service Journal, Sixty years of the National Health Service: Anniversary Supplement*, July 2008, p 7.
[70] Margaret Thatcher Foundation, 'TV Interview for BBC1 *Panorama* (announces NHS review)', 25 January 1988.
[71] Department of Health, *Working for Patients*, January 1989, Cm 555.
[72] House of Commons Library, *Selected Highlights in the History of the National Health Service*, 12 November 2008, pp 5–6; and Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 36.

mentally ill, people with learning disabilities and the elderly, and ambulance services).[73] To become a 'provider', the health organisations needed to become NHS trusts, which were independent organisations with their own management.

Many family doctors were given budgets with which to buy healthcare from NHS trusts and from the private sector, in a scheme called 'GP fund holding'.[74] Those who did not have their own budgets had services purchased for them by health authorities that bought in 'bulk' from NHS trusts.

The Labour Party argued that the proposals were part of a movement towards privatisation of the service.[75] The BMA also voiced opposition to the proposals, and launched a poster campaign to criticise the reforms. Nevertheless, the legislation was successfully passed and the first 57 trusts came into being in April 1991.

6.3 Private Finance Initiative

The Private Finance Initiative (PFI) was announced by the Chancellor of the Exchequer, Norman Lamont, in the 1992 Autumn Statement. The aim was to increase the involvement of the private sector in the provision of public services.[76] PFI is a form of public private partnership (PPP) that marries a public procurement programme, where the public sector purchases capital items from the private sector, to an extension of contracting-out, where public services are contracted from the private sector.[77] PFI in one form or another was used for many core public sector building projects, including hospitals, but also schools, roads and prisons. The policy has continued under successive governments.[78]

In terms of capital value, the NHS is the largest user of PFI funding.[79] As of May 2017, there were 150 projects ongoing in healthcare across the UK, with total capital values (the upfront cost of the projects) of £14.2 billion.[80] The regional breakdown, as of 31 March 2017, is presented in Table 1.

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[73] Drew Clawson et al, *60 Years of the National Health Service: From Past to Present*, 2008, p 36.
[74] ibid.
[75] Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention*, 2010, p 153.
[76] HC *Hansard*, 12 November 1992, col 998.
[77] PFI differs from privatisation in that the public sector retains a substantial role in PFI projects, either as the main purchaser of services or as an essential enabler of the project. See: House of Commons Library, *The Private Finance Initiative (PFI)*, 18 December 2001, p 10.
[78] The National Audit Office's report, *PFI and PF2* (18 January 2018, HC 718 of session 2017–19) provides further information on the current policy, costs and benefits of PFI.
[79] HM Treasury and Infrastructure Projects Authority, *Private Finance Initiative and Private Finance 2 Projects: 2017 Summary Data*, March 2018, p 7.
[80] HM Treasury and Infrastructure Projects Authority, 'Private Finance Initiative and Private Finance 2 Projects: 2017 Summary Data: Current Projects as at 31 March 2017', 29 March 2018, spreadsheet filtered on 'Sector = Hospitals and Acute Health'.

Table 1: Ongoing PFI Projects in Hospitals and Acute Health by Country, 31 March 2017[81]

	Number of Projects	Total Capital Value £ billion
England	109	12.6
Scotland	27	1.23
Wales	9	0.113
Northern Ireland	5	0.333

For these 150 projects, ongoing payments will continue until 2049/50 and will total around £64 billion.[82] These payments cover debt repayment, financing costs, maintenance and any other services provided, for example cleaning, maintenance and security.[83]

The National Audit Office (NAO) suggests:

> In the first twelve years of PFI use in the health sector, PFI resulted in extra capital investment for the Department of Health and Social Care (the Department) of around £0.9 billion each year on average: £0.5 billion a year more than the average annual spending of the Department on operational PFI projects over the same period. However, in recent years PFI has been used much less by the Department and the operational PFI contracts, which cost over £2 billion a year, have reduced the Department's budget flexibility.[84]

The NAO concluded that it had "been unable to identify a robust evaluation of the actual performance of private finance at a project or programme level".[85] The use of PFI has slowed significantly in recent years, with only one deal (not in the health sector) completed across the whole of government in 2016/17.[86] The NAO reports that the most frequently cited reason for the reduced use of PFI is "concerns about cost efficiency and value for money".[87]

7. NHS After Devolution

The Labour Party won the general election in 1997. In 1998, the UK Parliament passed legislation introducing schemes of devolution in Scotland,

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[81] HM Treasury and Infrastructure Projects Authority, 'Private Finance Initiative and Private Finance 2 Projects: 2017 Summary Data: Current Projects as at 31 March 2017', 29 March 2018, spreadsheet filtered on 'Sector = Hospitals and Acute Health'.
[82] ibid, spreadsheet filtered on 'Sector = Hospitals and Acute Health', total of Estimated Unitary Charge Payments from 2018/19 onwards.
[83] National Audit Office, *PFI and PF2*, 18 January 2018, HC 718 of session 2017–19, p 4; and House of Commons Library, *PFI: Costs and Benefits*, 13 May 2015, p 11.
[84] ibid, p 12.
[85] National Audit Office, *PFI and PF2*, 18 January 2018, HC 718 of session 2017–19, p 18.
[86] ibid, p 23.
[87] ibid.

Wales and Northern Ireland respectively: the Scotland Act 1998; the Government of Wales Act 1998 (which was later effectively superseded by the Government of Wales Act 2006); and the Northern Ireland Act 1998.[88] As a result, health became a largely devolved matter, which has led to a greater divergence of policy than previously between the different countries in the UK.[89]

Prior to devolution, the Secretaries of State for Scotland, Wales and Northern Ireland were accountable for expenditure on public services within each country.[90] They were each allocated a global sum for their public services, and were free to allocate money to their chosen spending priorities. The Barnett Formula used in making global allocations to the devolved countries began to operate in Scotland and Northern Ireland in 1979, and in Wales in 1980 (when political devolution was first being considered). This formula, in principle, uses data on crude population figures to allocate increases in spending on public services in England to the devolved countries.

The arrangements for devolution mean that, in effect, since 1999 there have been two different systems for determining health service budgets: one system applied to England only; the other to the devolved countries.[91] The NHS budget for England is the outcome of UK cabinet agreements following negotiations between HM Treasury and the Department of Health and Social Care. The Treasury also sets the global allocations for 'public services' in the devolved countries, but each devolved government decides how much of its global allocation ought to be allocated to the NHS.[92] The Scottish Executive has certain additional tax raising powers, and therefore, can make its own adjustments to its overall funding envelope.

The following sections provide an overview of some key reforms made to the health service after devolution in each of the four countries in the UK, as well as a summary of the current structures in each.

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[88] Further powers have been devolved since these original acts, most recently through the Scotland Act 2016 and Wales Act 2017.

[89] House of Commons Library, *Selected Highlights in the History of the National Health Service*, 12 November 2008, p 6; and Health Foundation and Nuffield Trust, *The Four Health Systems of the United Kingdom: How Do They Compare?*, April 2014, p 6.

[90] Health Foundation and Nuffield Trust, *The Four Health Systems of the United Kingdom: How Do They Compare?*, April 2014, p 24.

[91] ibid; and National Assembly of Wales Research Service, *The Organisation of the NHS in the UK: Comparing Structures in the Four Countries*, May 2015, p 6.

[92] ibid.

7.1 England

Reforms Under the Labour Government (1997–2010)

In December 1997, the Labour Government published the white paper, *The New NHS: Modern, Dependable*, which set out its policies for reform.[93] The white paper committed the Government to "reducing bureaucracy by abolishing the internal market", replacing it with a system based on cooperation and partnership.[94] However, it retained the separation of purchasers and providers.[95]

In March 2000, the then Chancellor of the Exchequer, Gordon Brown, announced in the Budget an increase in NHS funding to support the Government's plans for "reforms and modernisation of the health service".[96] In July 2000, the Government published *The NHS Plan: A Plan for Investment, A Plan for Reform*, which set out a ten-year modernisation programme of investment and reform.[97] The objective of the Plan was to expand capacity and provide greater patient choice. The aim was to deliver maximum waits for GP appointments, outpatient appointments and hospital admissions. It also provided the basis for greater use of the private sector by the NHS; a new contract for GPs; expansion of training for doctors and nurses; and the establishment of new medical schools.[98]

In 2002, the white paper, *Shifting the Balance of Power*, was published. This led to the abolition of 95 health authorities.[99] Much of the planning and commissioning work carried out by the health authorities passed to just over 300 primary care trusts (PCTs). In addition, 28 strategic health authorities (SHAs) were established to provide regional management for the NHS and to oversee the work of the PCTs and NHS trusts. However, a further reorganisation took place in 2006, and the number of PCTs were reduced from 303 to 152, and the number of SHAs from 28 to 10.

A new type of body, the NHS foundation trust, was created under the provisions of the Health and Social Care (Community Health and Standards) Act 2003. The first trusts were launched in April 2004. Foundation trusts were to have greater independence from central government than the traditional NHS trust; they would not be performance managed by health

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[93] Department of Health, *The New NHS: Modern, Dependable*, December 1997, Cm 3807.
[94] ibid; and Tony White, *A Guide to the NHS*, 2010, p 76.
[95] House of Commons Library, *Selected Highlights in the History of the National Health Service*, 12 November 2008, p 6.
[96] HC *Hansard*, 21 March 2000, cols 871–2.
[97] Tony White, *A Guide to the NHS*, 2010, p 76.
[98] ibid; and House of Commons Library, *Selected Highlights in the History of the National Health Service*, 12 November 2008, p 6.
[99] National Archives, 'Shifting the Balance of Power', accessed 24 May 2018; and Nuffield Trust, 'The History of NHS Reform', accessed 24 May 2018.

authorities.[100] Local people could become board members and governors.

In June 2008, Lord Darzi, then Parliamentary Under Secretary of State for Health, published his review of the service, *High Quality Care for All*.[101] Lord Darzi defined quality of care as clinically effective, personal, and protecting patient safety by eradicating healthcare acquired infections and avoidable accidents. The Darzi Report was accompanied by a consultation on a draft NHS constitution, and a document on primary and community care, *NHS Next Stage Review: Our Vision for Primary and Community Care*. The review set out proposals to improve patient choice, preventative healthcare, new ways to measure quality, and workforce planning and education.[102]

In January 2009, the first NHS Constitution was published.[103] It set out seven principles on how the NHS should act and make decisions, six core values and a number of pledges to patients and staff, as well as a list of their rights and responsibilities. This included treating patients with dignity and respect, and enabling informed choice. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of the Constitution in their decisions and actions.[104] The most recent Constitution was published in 2015, and reaffirmed the principles that the NHS is a comprehensive service available to all, and not based on an individual's ability to pay.[105]

Reforms Since 2010

In July 2010, the Coalition Government published the white paper, *Equality and Excellence: Liberating the NHS*.[106] This set out the then Government's aims to reduce central control of the NHS, to engage doctors in the commissioning of health services, and to give patients greater choice.[107]

The Health and Social Care Act 2012 introduced a number of reforms to the structure of the NHS. Many of the provisions under the Act came into force on 1 April 2013:

- NHS England and clinical commissioning groups (CCGs) took on statutory responsibility for commissioning health services.

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[100] NHS Choices, 'The NHS in England', accessed 24 May 2018.
[101] Department of Health, *High Quality Care for All: Next Stage Review Final Report*, June 2008, Cm 7432.
[102] Department of Health, *NHS Next Stage Review: Our Vision for Primary and Community Care*, July 2008.
[103] Nuffield Trust, 'The History of NHS Reform', accessed 24 May 2018.
[104] Department for Health and Social Care, 'The NHS Constitution for England: Guidance', accessed 28 May 2018.
[105] Department of Health and Social Care, *The NHS Constitution for England*, July 2015.
[106] Department of Health, *Equity and Excellence: Liberating the NHS*, July 2010, Cm 7881.
[107] ibid, pp 1–6; and House of Commons Library, *The Structure of the NHS in England*, 7 July 2017, p 6.

- Local authorities took on new public health responsibilities.
- Strategic health authorities and PCTs were formally abolished.[108]

In October 2014, the NHS *Five Year Forward View* was published. It identified three key drivers for change: health and wellbeing, care and quality, and funding efficiency.[109] The document called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes. In January 2015, as "one of the first steps towards delivering the *Five Year Forward* View", individual organisations and partnerships were invited to apply to become 'vanguards' to develop the new care model.[110] There are 50 vanguards.[111]

In 2015, NHS organisations were asked to come together to create local blueprints for delivering the *Five Year Forward View*, known as sustainability and transformation plans (STPs).[112] By the end of January 2016, local NHS services and local authorities had formed 44 separate sustainability and transformation 'footprints'. Each of the 44 'footprints' are separate partnerships made up of NHS organisations, including clinical commissioning groups (CCGs), NHS trusts and foundation trusts and primary care services, as well as local authorities.

In March 2017, the document, *Next Steps on the NHS Five Year Forward View,* was published. It set out the NHS' main national service improvement priorities over the succeeding two-year period.[113] The priority areas identified in the report included:[114]

- Improving Accident and Emergency (A&E) performance and upgrading the wider urgent and emergency care system to manage demand growth and improve patient flow in partnership with local authority social care services.
- Strengthening access to high quality GP services and primary care.
- Improvements in cancer services (including performance against waiting times standards) and mental health.

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108 House of Commons Library, *The Structure of the NHS in England*, 7 July 2017, p 6.
109 NHS England, *Five Year Forward View*, October 2014, pp 6–8.
110 NHS England, *New Care Models: Vanguards—Developing a Blueprint for the Future of NHS and Care Services*, September 2016, p 3; and NHS England, 'The NHS in England', accessed 29 May 2018.
111 NHS England, 'About Vanguards', accessed 12 June 2018.
112 House of Commons Library, *Sustainability and Transformation Plans and Partnerships*, 29 September 2017, p 5; and The King's Fund, 'Sustainability and Transformation Plans (STPs) Explained', 21 February 2017.
113 NHS England, *Next Steps on the NHS Five Year Forward View*, March 2017, p 4.
114 House of Commons Library, *The Structure of the NHS in England*, 7 July 2017, p 9.

In January 2018, the new Department of Health and Social Care was created.[115] In May 2018, the Department published its *Single Departmental Plan*.[116] One of the key objectives identified was to "support the NHS to deliver high quality, safe and sustainable hospital care and secure the right workforce".

Current Structure of the NHS in England

The Secretary of State has overall responsibility for the work of the Department of Health and Social Care.[117] The Department provides strategic leadership for public health, the NHS and social care in England.

NHS England is an independent body, whose main role is to set the priorities and direction of the NHS.[118] It is the commissioner for primary care services such as GPs, pharmacists and dentists, including military health services and some specialised services.

Clinical commissioning groups (CCGs) replaced PCTs on 1 April 2013.[119] CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. CCG members include GPs and other clinicians, such as nurses and consultants. CCGs can commission any service provider that meets NHS standards and costs.

Under the provisions of the Health and Social Care Act 2012, responsibility for the provision of a range of public health services was transferred from the NHS to local authorities in 2013.[120] In addition, Public Health England (PHE) was established as a directorate within the then Department of Health. It has taken on responsibilities to provide national leadership and expert services to support public health, and also works with local government and the NHS to respond to emergencies.

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[115] Prime Minister's Office, 'Ministerial Appointments: January 2018', 9 January 2018.
[116] Department of Health and Social Care, 'Department of Health and Social Care: Single Departmental Plan', updated 23 May 2018.
[117] NHS England, 'The NHS in England: Structure', accessed 29 May 2018. Further information about the current structure of the NHS in England can be found in the House of Commons Library briefing *The Structure of the NHS in England* (7 July 2017) and the King's Fund briefing, 'How is the NHS Structured?' (16 April 2016).
[118] NHS England, 'The NHS in England: Structure', accessed 29 May 2018.
[119] ibid.
[120] House of Commons, *70th Anniversary of the NHS and Public Health*, 15 May 2018, p 5; and NHS England, 'The NHS in England: Structure', accessed 29 May 2018.

7.2 Northern Ireland

Governance Before Devolution

The creation of the NHS in 1948 had established largely the same organisational forms across the UK.[121] The regulations to control the distribution of GPs was implemented by three medical practice committees; one for England and Wales, Scotland and Northern Ireland respectively. A hospital management committee governed each hospital in Northern Ireland, and was accountable to the Northern Ireland Hospital Authority (in contrast to the 14 regional hospital boards in England and Wales).

During the reorganisation of the NHS in the 1970s, four health and social service boards, the boundaries of which were based around the council districts, were created in Northern Ireland.[122] The boards became responsible for health and social services. The management structure of the new boards was based on a system of teams and committees.[123] Overall, the Ministry of Health and Social Services decided priorities and standards as well as financing the service. It delegated to the boards the framing and delivery of services within their respective areas.

Following the introduction of an 'internal market' in the NHS in the 1990s, health and social services boards in Northern Ireland became purchasers, and their hierarchical role in governing providers was replaced with contractual arrangements, as providers became more autonomous NHS trusts.[124]

Reform After Devolution

Suspension of the Northern Ireland Assembly resulted in stasis in the development of health policy through much of the post-devolution period.[125] The Health and Social Care (Reform) Act (Northern Ireland) 2009 created one large commissioning body, the Health and Social Care Board. It was supported by five local commissioning groups organised geographically, and five coterminous health and social care trusts, established to provide care.[126]

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[121] Health Foundation and Nuffield Trust, *The Four Health Systems of the United Kingdom: How Do They Compare?*, April 2014, p 27; and Rodney Lowe, *The Welfare State in Britain since 1945*, 2005.
[122] ibid.
[123] Northern Ireland Public Health Agency, *Four Decades of Public Health: Northern Ireland's Health Boards 1973–2009*, November 2010, p 10.
[124] ibid.
[125] ibid; and Health Foundation and Nuffield Trust, *The Four Health Systems of the United Kingdom: How Do They Compare?*, April 2014, p 30. Further information about the suspension of the Northern Ireland Assembly in the period immediately following devolution can be found on the Northern Ireland Assembly website, 'History of the Assembly' (accessed 24 May 2018).
[126] ibid, p 30; and National Assembly of Wales Research Service, *The Organisation of the NHS in the UK: Comparing Structures in the Four Countries*, May 2015, p 3.

The structure maintained a purchaser/provider split, but the policy emphasis was on cooperation, and not provider competition.

In 2011, the Northern Irish Government commissioned report, *Transforming Your Care*, highlighted an overreliance on inpatient hospital care for patients over treatment closer to home or in the community. The report suggested that this model was unsustainable in the long-term.[127] To counter this, the report proposed the creation of 17 Integrated Care Partnerships (ICPs). ICPs are networks of care providers, consisting of healthcare professionals, local authority representatives, voluntary sector representatives, and service users and carers.[128] The intention was ICPs would develop and coordinate local health and social care services to be delivered as close to home as possible.[129]

In April 2014, the then Health Minister, Edwin Poots, commissioned the former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on health and social care governance arrangements. His report, *The Right Time, The Right Place*, was published in December 2014.[130] Based on one of the Donaldson recommendations, in early 2016, the then Health Minister, Simon Hamilton, appointed an expert, clinically-led panel, chaired by Raphael Bengoa, to lead debate on the best configuration of health care services for Northern Ireland.[131] Following the expert panel report on health and social care reform, *Systems, Not Structures*,[132] the Department of Health published its ten-year strategy in October 2016, *Health and Wellbeing 2026*.[133] This reiterated the commitment to increasing home and community treatment, and to more preventative work.[134]

Current Structure of Healthcare in Northern Ireland

The healthcare service in Northern Ireland provides both health and social care and is administered by the Department of Health.[135]

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[127] Health and Social Care Board, *A Review of Health and Social Care in Northern Ireland*, December 2011.
[128] House of Commons Library, *Health and Social Care Integration*, 25 October 2017, p 35.
[129] Further information on the delivery of the 'Transforming Your Care' programme can be found on the Northern Ireland Department of Health website, 'Transforming Your Care', accessed 27 May 2018.
[130] Northern Ireland Department of Health, *The Right Time, The Right Place*, December 2014.
[131] House of Commons Library, *Health and Social Care Integration*, 25 October 2017, p 35.
[132] Northern Ireland Department of Health, *Systems, Not Structures: Changing Health and Social Care*, October 2010.
[133] Northern Ireland Department of Health, *Health and Wellbeing 2026: Delivering Together*, October 2016.
[134] Further information on the progress of implementing the strategy can be found on the Northern Ireland Department of Health website, 'Health and Wellbeing 2026: Delivering Together', accessed 27 May 2018.
[135] NI Direct, 'Changes to Government Departments', accessed 27 May 2018.

The Health and Social Care Board holds overall responsibility for commissioning services through five local commissioning groups, which are committees of the Health and Social Care Board.[136] Five health and social care trusts have responsibility for providing integrated health and social care in their regions.[137] The Northern Ireland Ambulance Service is designated as a sixth region-wide trust. A separate Public Health Agency has responsibility for improving health and wellbeing and health protection.

7.3 Scotland

Governance Before Devolution

The Secretary of State for Scotland and the Scottish Office (created in 1885) was responsible for the healthcare in Scotland before devolution.[138] When the NHS was created, regulation of family doctor services in Scotland was implemented by the medical practice committee for Scotland, and organisation of hospitals was based on five regional hospital boards.

Following the reorganisation of the NHS in Scotland in 1974, health boards were created with equivalent responsibilities to both area health authorities and family health service authorities in England and Wales.[139] The post of Medical Officer of Health was abolished.[140]

Reform of the NHS after Devolution

In the first and second session of the Scottish Parliament, the Labour-Liberal Democrat coalition implemented policies intended to "dismantle" the 'internal market'.[141] The National Health Service Reform (Scotland) Bill was introduced in 2003. It sought to abolish NHS trusts in Scotland and to integrate the management of acute and primary care services into NHS boards. The Bill was passed into law in 2004. The Act also increased the powers of the Health Minister to intervene in failing organisations, introduced a duty of cooperation on health boards and allowed for "greater involvement of the public in service planning".[142]

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[136] Health and Social Care Board, 'About Us', accessed 27 May 2018.
[137] Health and Social Care Board, 'Health and Social Care Trusts', accessed 27 May 2018.
[138] Health Foundation and Nuffield Trust, *The Four Health Systems of the United Kingdom: How Do They Compare?*, April 2014, p 27; and Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, p 182.
[139] ibid.
[140] NHS Scotland, 'Explore the History of the NHS in Scotland', accessed 24 May 2018.
[141] SPICe, *The National Health Service in Scotland*, December 2016, p 8; and Health Foundation and Nuffield Trust, *The Four Health Systems of the United Kingdom: How Do They Compare?*, April 2014, p 29.
[142] National Assembly of Wales Research Service, *The Organisation of the NHS in the UK: Comparing Structures in the Four Countries*, May 2015, p 3.

When the Scottish National Party (SNP) came to power in 2007, there was no manifesto pledge for a radical reorganisation of the NHS.[143] However, it did include a commitment to operate "a presumption against the centralisation of core hospital services".[144]

The paper, *Better Health, Better Care*, also published in 2007, set out the SNP Government's plan to create a "mutual NHS", where NHS staff and patients were treated as "co-owners of the NHS".[145] This resulted in a number of initiatives to shift ownership and accountability, including the Patient Rights (Scotland) Act 2011, with its key policy of a statutory treatment time guarantee. Other key policy developments taken forward by the SNP Government between 2007 and 2016 included:[146]

- The publication of the NHS Quality Strategy in 2010, which set out a number of priorities including: effective collaboration between clinicians, patients and others; continuity of care; and clinical excellence.[147]
- The publication of the 2020 vision which set out the Scottish Government's aim to enable everyone to live longer, healthier lives at home or in a home setting.[148]

Prior to the Scottish Parliament elections in May 2016, the Scottish Government published the *National Clinical Strategy for Scotland*.[149] It set out the Government's intended blueprint for health services in Scotland for the next ten to 15 years. The Scottish Government's priorities included:

- The balance of care to be shifted away from the acute sector towards the community.
- Provision of care that is person centred rather than condition focussed.
- Transformation of primary care by increasing recruitment of GPs and developing technological solutions.
- Services to be planned and delivered across populations, regardless of geographical locality.[150]

In December 2016, the Scottish Government published its *Health and Social Care Plan*.[151] The delivery plan set out the Scottish Government's aim to

[143] SPICe, *The National Health Service in Scotland*, December 2016, p 9.
[144] Scottish National Party, *Manifesto 2007*, April 2007, p 6.
[145] NHS Scotland, *Better Health, Better Care*, 2007, p v.
[146] SPICe, *The National Health Service in Scotland*, December 2016, p 9.
[147] NHS Scotland, *The Healthcare Quality Strategy for NH Scotland*, May 2010.
[148] Scottish Government, '2020 Vision', accessed 27 May 2018.
[149] Scottish Government, *National Clinical Strategy for Scotland*, February 2016.
[150] Further information on recent developments and key issues related to the NHS in Scotland can be found in the SPICe briefing, *The National Health Service in Scotland*, (December 2016).
[151] Scottish Government, *Health and Social Care Delivery Plan*, 19 December 2016.

provide an integrated health and social care system that focused on prevention, early intervention and supported self-management.[152] The document reiterated the Government's objective to put patients at the centre of all decisions, with people getting back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Current Structure of the NHS in Scotland

NHS Scotland consists of:

- Fourteen regional NHS boards that are responsible for the "protection and the improvement of their population's health and for the delivery of frontline healthcare services".
- Seven special NHS boards, and one public health body, named Healthcare Improvement Scotland, that "support the regional NHS boards by providing a range of important specialist and national services".[153]

Each NHS board is accountable to Scottish Ministers. The Cabinet Secretary for Health and Wellbeing has ministerial responsibility in the Scottish Cabinet for the NHS in Scotland.[154]

The Public Bodies (Joint Working) (Scotland) Act 2014 put in place a requirement on NHS boards and local authorities to integrate health and social care.[155] The Act allows boards and local authorities to integrate health and social care in two ways:

- The health board and local authority delegate responsibility for planning and resourcing service provision for adult health and social care services to an integration joint board.
- The health board or the local authority takes the lead responsibility for planning, resourcing and delivering integrated adult health and social care services.

7.4 Wales

Governance Before Devolution

Following the inauguration of the NHS in 1948, 14 regional hospital boards were established in England and Wales, including the Welsh Regional

[152] Scottish Government, *Health and Social Care Delivery Plan*, 19 December 2016, p 3.
[153] NHS Scotland, 'Organisations', accessed 24 May 2018.
[154] NHS Scotland, 'NHS Scotland: How it Works', accessed 5 June 2018.
[155] House of Commons Library, *The Structure of the NHS in England*, 7 July 2017, p 34

Hospital Board, which covered Wales.[156] The regional boards in England and Wales were charged with the planning of the service and the supervision of hospital management committees. General practitioners were self-employed under a contract for services from an executive council.

In 1969, the Secretary of State for Wales took over much of the responsibility for health services in Wales, and was supported in this by the Welsh Office, which had been established in 1964.[157] In 1974, the NHS was reorganised in England and Wales. Area health authorities (AHAs) were created which took over responsibility for running both hospital and community services from the hospital boards and local authorities. The primary care services provided by independent contractors remained outside the control of AHAs, with executive councils replaced by family practitioner committees (FPCs), who administered the contracts of GPs, dentists, pharmacists and opticians.[158] England also had regional health authorities (RHAs) with overall responsibility lying with the Department of Health and Social Security (DHSS).[159] In Wales, the Welsh Office had both regional and central government departmental responsibilities under the political control of the Secretary of State for Wales.[160]

In 1982, the eight area health authorities in Wales became nine district health authorities (DHAs).[161] The majority of the new DHAs had the same boundaries as county councils and the FPCs. When the 'internal market' was introduced in the NHS in 1990, DHAs and the newly established GP fundholders were to act as the purchasers in the system and to negotiate contracts with providers of health services. Family health services authorities replaced the FPCs, but with similar responsibilities for the contractual arrangements of doctors, dentists, pharmacists and opticians. In 1996, the DHAs and family health services authorities merged into five health authorities covering the whole of Wales.

Reform of the NHS after Devolution

In 2007, a minority Labour Welsh Assembly Government published the strategy document, *One Wales*, which determined that the delivery of the NHS in Wales needed to be redesigned.[162] It set out the Government's intention to remove the 'internal market'. The reorganisation of NHS Wales, which came into effect in October 2009, created integrated local health

[156] NHS Wales, 'Historical Context', accessed 24 May 2018; and Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, p 182.
[157] NHS Wales, 'Historical Context', accessed 24 May 2018; and National Archives, 'Records of the Welsh Hospital Board', accessed 24 May 2018.
[158] Rodney Lowe, *The Welfare State in Britain since 1945*, 2005, p 196.
[159] NHS Wales, 'Historical Context', accessed 24 May 2018.
[160] ibid; and National Archives, 'Records of the Welsh Hospital Board', accessed 24 May 2018.
[161] NHS Wales, 'Historical Context', accessed 24 May 2018.
[162] Welsh Assembly Government, *One Wales: A Progressive Agenda for the Government of Wales*, 27 June 2007, p 9.

boards that were responsible for delivering all healthcare services within a geographical area, rather than the trust and local health board system that existed previously.[163] This replaced the 'internal market', and removed the purchaser-provider split in Wales. [164]

In September 2017, the Welsh Government published its national strategy, *Prosperity for All*.[165] The document set out the Government's key priorities, which included improving the "health and well-being in Wales, for individuals, families and communities".[166] It presented the Government's plans to "deliver quality health and care services fit for the future" by:

- Continuing to improve further the standard, quality and timeliness of treatment across the NHS.
- Further integration of health and social care and publishing a long-term plan for the NHS and social care in Wales.
- Delivering a tangible shift in the provision of health and care services into communities, and away from hospitals, and shift the emphasis from treating illness to well-being.
- Investing in a new generation of integrated community health and care centres, which focus on the specific needs of their local areas.
- Ensuring that organisations delivering health and care services pool budgets and commission jointly, delivering a genuinely seamless service for those who need it.[167]

Current Structure of the NHS in Wales

In Wales, seven local health boards (LHBs) are responsible for planning and delivering healthcare services, and aim to integrate specialist, secondary, community and primary care and health improvements.[168] There are three all-in-Wales NHS trusts: The Welsh Ambulance Service, Velindre NHS trust (providing specialist services in cancer and other national support) and Public Health Wales.

The Cabinet Secretary for Health and Social Services is directly responsible for the delivery of health services.[169] The NHS in Wales is accountable to both Welsh ministers and to community health councils, which provide a

[163] Health in Wales, 'Structure', accessed 27 May 2018; and Welsh Assembly Government, *NHS in Wales: Why We Are Changing the Structure*, October 2009, p 1.
[164] Welsh Assembly Government, *NHS in Wales: Why We Are Changing the Structure*, October 2009, p 3; and 'NHS Confederation: About the NHS in Wales', 1 February 2018.
[165] Welsh Government, *Prosperity for All: The National Strategy*, September 2017.
[166] ibid, p 12.
[167] ibid.
[168] Health in Wales, 'Structure', accessed 27 May 2018; and National Assembly of Wales Research Service, *The Organisation of the NHS in the UK: Comparing Structures in the Four Countries*, May 2015, pp 18–20.
[169] Welsh Government, 'Cabinet Secretaries and Ministers', accessed 27 May 2018.

link between patients and the organisations that plan and deliver services.[170] Community health councils in Wales are statutory lay bodies that represent the interests of the public in the health service in their district.

8. NHS in Numbers

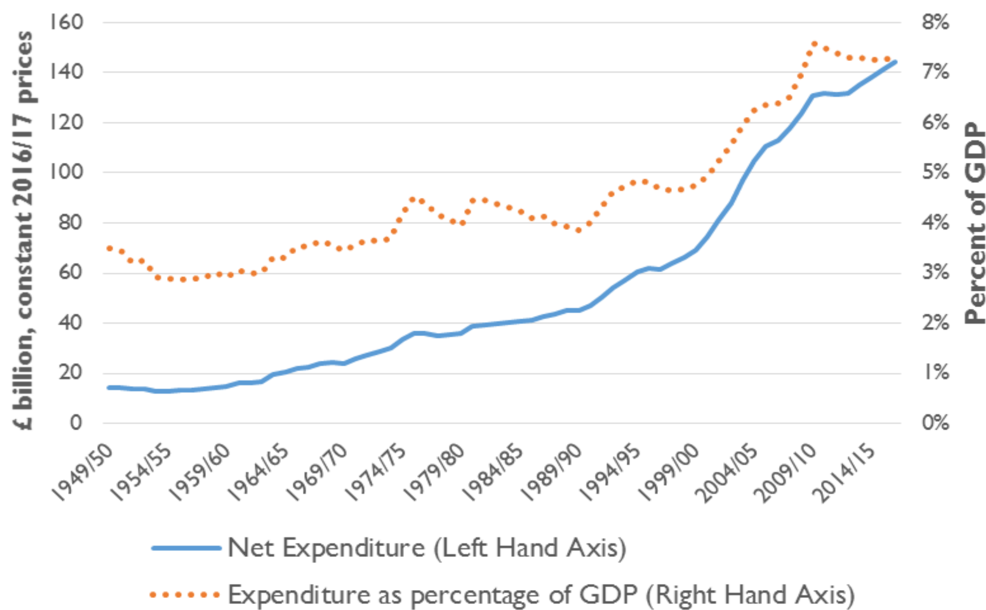
8.1 Cost of the NHS

Overall Cost

The cost of the NHS in the UK was £144 billion in 2016/17,[171] compared with £447 million in 1949/50, its first full year of operation.[172] Figure 1 shows that NHS expenditure has risen more than tenfold in real terms (ie adjusted for inflation) since 1950/51, and has more than doubled as a percentage of Gross Domestic Product (GDP) to reach 7.3 percent.

Figure 1: Cost of the NHS has Risen on Two Key Measures

NHS spending in £ billion (constant 2016/17 prices) and as a percentage of GDP, UK[173]



[170] House of Commons Library, The Structure of the NHS in England, 7 July 2017, p 35.
[171] House of Commons Library, NHS Funding and Expenditure, 13 April 2018, p 11.
[172] Emma Hawe and Lesley Cockcroft, Office of Health Economics Guide to UK Health and Healthcare Statistics, Office of Health Economics, October 2013, p 45.
[173] House of Commons Library, NHS Funding and Expenditure, 13 April 2018, p 11. Note that there are several changes in the way spending has been measured over time and some inconsistency between sources, so these figures should be treated as indicative only. See, for example, the notes to table 1 in the House of Commons Library briefing, NHS Funding and Expenditure; and Tony White, *A Guide to the NHS*, 2010, p 124.

On a per head of population basis, UK NHS spending in real terms has risen from £285 in 1950/51 to £2,200 in 2016/17.[174]

The Institute for Fiscal Studies (IFS) has predicted that spending will need to rise further from the current 7.3 percent of GDP to 8.9 percent in 15 years' time to maintain the same level of service as today.[175] The Office for Budget Responsibility takes an even longer-term view; on its projections, "public spending on health [would reach] 12.6 percent of national income in 2066/67".[176]

Drivers of Costs

A recent study by the IFS and the Health Foundation (HF) identified the key factors behind rising NHS costs as:

- rising incomes and expectations;
- the size of the overall population;
- the ageing of the population;
- higher costs of medicines;
- an increase in chronic conditions; and
- increasing wages of the NHS workforce.[177]

Technological change and an increase in chronic conditions alone have been estimated to add 1.6 percent per annum to health costs.[178]

The study particularly highlighted the way that the UK's ageing population has placed strains on the NHS and will continue to do so.[179] It stated that while expenditure per head since 2009/10 has risen by 0.6 percent per year in real terms, once adjusted for the demographic profile this falls to just 0.1 percent.[180] By 2033/34, it suggested, there will be 4.4 million more people over the age of 65, and 1.3 million more people aged over 85. The study found that on average, "public health spending was five times greater for an 85-year-old than for a 30-year-old in 2015".[181]

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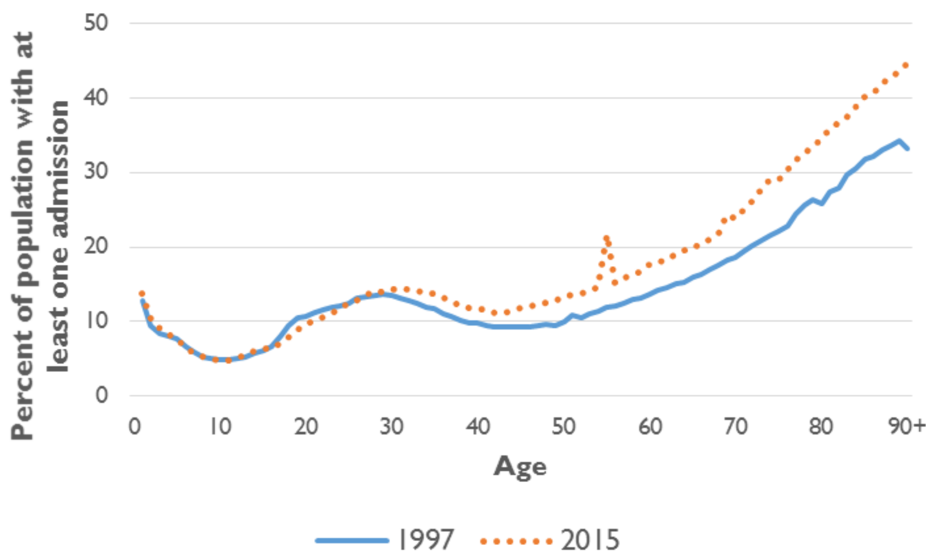
[174] House of Commons Library, *NHS Funding and Expenditure*, 13 April 2018, p 11, combined with population estimates from Office for National Statistics, 'Mid-1851 to Mid-2014 Population Estimates for the United Kingdom', accessed 23 May 2018 (for 1950–70); and Office for National Statistics, 'United Kingdom Population Mid-year Estimate', 22 June 2017 (for 1971–2016).
[175] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018, p vi.
[176] George Stoye, *UK Health Spending*, Institute for Fiscal Studies, 2017, p 12.
[177] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018, pp 15–16.
[178] George Stoye, *UK Health Spending*, Institute for Fiscal Studies, 2017, p 9.
[179] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018.
[180] ibid, p iv.
[181] George Stoye, *UK Health Spending*, Institute for Fiscal Studies, 2017, p 8.

Overall, the report suggested that UK spending on healthcare will need to rise at 3.3 percent per year over the next 15 years to maintain current healthcare standards.[182]

The study included the following chart. It suggests that, over time, people of all ages have become more likely to use one of the NHS's more expensive services, an inpatient admission. In addition, the average number of admissions per person at each age has also risen.[183]

Figure 2: People at All Ages are More Likely to Have an Inpatient Hospital Stay[184]

Percentage of population (England) by age who had at least one inpatient admission in the year (age 0 omitted)



Areas of Exceptional Cost Increases

In his book marking the 50th year of the NHS, Geoffrey Rivett remarked that "in medicine more has happened since 1948 than in all the centuries back to Hippocrates".[185] Reflecting these advances, statistics show that the cost of medicines has risen faster than overall NHS spending. Healthcare think tank the King's Fund suggested that this has been a significant factor in the growth of NHS expenditure in recent years.[186] It reported that expenditure on drugs in England rose by 5 percent per year between 2010/11 to 2016/17, while overall NHS spending rose by only 1.5 percent per year (although it notes a number of caveats on the reliability of the

[182] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018, p ii.
[183] ibid.
[184] ibid, p 49.
[185] Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*, 1998, p 470.
[186] Leo Ewbank et al, *The Rising Costs of Medicines to the NHS: What's the Story?*, King's Fund, April 2018.

statistics).[187] The upwards pressure is much more marked in the total cost of hospital medicines, which has grown at 12 percent per year, while in primary care (for example, GPs) the increase was only 0.6 percent.[188] The King's Fund suggested that it is not possible to explain exactly what is causing this increase in hospital medicine costs, but increases in both patient numbers and the cost of new medicines are possible causes.[189]

Taking a longer-term perspective, total medicine costs of £17.4 billion in 2016/17 would represent 12.2 percent of total NHS costs in England.[190] The Office for Health Economics suggested that the equivalent figure, although for the UK as a whole, was 8.3 percent in 1969, the earliest year quoted, and was as low as 5.4 percent in 1975.[191]

Compensation costs in the NHS are another area which, while small relative to overall spending on the NHS, are also increasing significantly more quickly than the overall cost. The National Audit Office (NAO) reported that the clinical negligence scheme cost £1.6 billion in 2016/17, a fourfold increase from £0.4 billion in 2006/07.[192] The NAO expected this figure to double again to £3.2 billion by 2020/21. It described provisions for all outstanding claims as "one of the biggest liabilities in the government accounts, and one of the fastest growing", standing at £60 billion in 2017.

8.2 Public and Private Healthcare Costs Compared

The cost of NHS expenditure in 2016/17 represented 7.3 percent of GDP. In comparison, spending on private healthcare and private medical insurance combined represented 2.0 percent of GDP,[193] an increase from 0.5 percent in 1974/75.[194] Just over 10 percent of the UK population was covered by private health insurance in 2015,[195] an increase from 1.2 percent in 1955.[196] In both its total health spending as a percentage of GDP and its public/private split, the UK is close to the EU average.[197]

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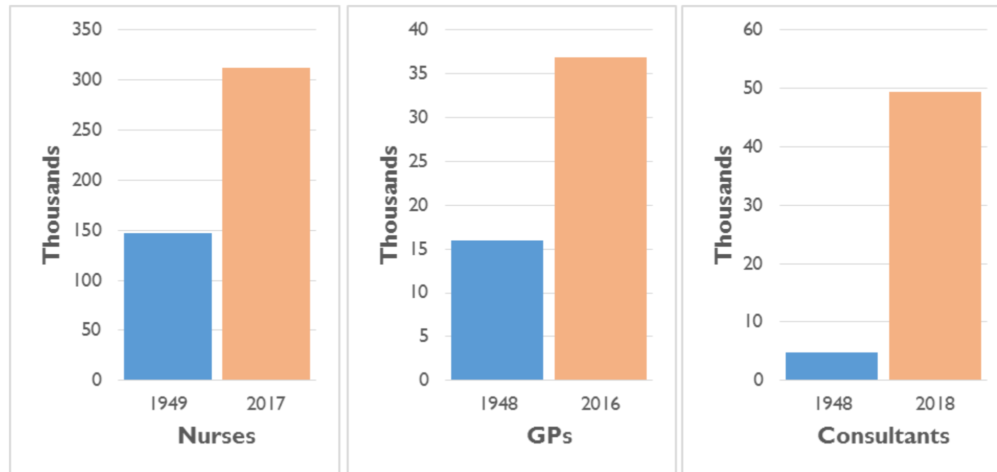
[187] Leo Ewbank et al, *The Rising Costs of Medicines to the NHS: What's the Story?*, King's Fund, April 2018, pp 6–8.
[188] ibid, p 7.
[189] ibid, p 13.
[190] ibid, p 2; and HM Treasury, *Country and Regional Analysis 2017*, November 2017, p 31.
[191] Emma Hawe and Lesley Cockcroft, *Office of Health Economics Guide to UK Health and Healthcare Statistics*, Office of Health Economics, October 2013, p 138.
[192] National Audit Office, *Managing the Costs of Clinical Negligence in Trusts*, 7 September 2017, HC 305 of session 2017–19.
[193] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018, p 9.
[194] Emma Hawe and Lesley Cockcroft, *Office of Health Economics Guide to UK Health and Healthcare Statistics*, Office of Health Economics, October 2013, p 35.
[195] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018, p 10.
[196] Emma Hawe and Lesley Cockcroft, *Office of Health Economics Guide to UK Health and Healthcare Statistics*, Office of Health Economics, October 2013, p 74.
[197] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018, p 10.

8.3 Other Measures of NHS Size

According to a 2015 study by Forbes, the UK's total NHS workforce of 1.7 million people made it the world's fifth largest employer.[198] Figure 3 shows how the number of nurses, GPs and consultants has increased since the early days of the NHS.

Figure 3: Increases in NHS Nurse, GP and Consultant Numbers, 1940s to Present Day[199]



Bed numbers have, in contrast, reduced significantly. Geoffrey Rivett states that at inception, there were 480,000 beds (including 190,000 for mental illness) in England and Wales.[200] In 2016/17, the average number of available beds in England and Wales was 141,800.[201] The reduction is partly because of the much more fragmented hospital system in the early days of the NHS.[202] Another factor is that, according to the IFS/HF report, "medical advances

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[198] Niall McCarthy, 'The World's Biggest Employers', Forbes, 23 June 2015.

[199] For nurses: Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*, 1998, pp 186 and 260 (for 1949, all nurses numbers exclude midwives and are on a full-time equivalent basis); NHS Digital, 'NHS Workforce Statistics, February 2018 National and HEE', 22 May 2018 (England, September 2017); Statistics for Wales, *Staff Directly Employed by the NHS in Wales, at 30 September 2017*, 28 March 2018, p 4 (Wales, September 2017; includes unqualified nursing staff). For GPs: Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*, 1998, p 80 (1948); NHS Digital, 'General Practice Provisional Tables March 2018', 15 May 2018, Table 1a (England in 2016; excludes registrars, retainers and locums); StatsWales, 'UK Comparisons of General Practitioners Workforce by Year', 29 March 2017 (Wales in 2016). For consultants: Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*, 1998, pp 100 and 137 (1948; it is not clear to which geographical regions these numbers apply); and NHS Digital, 'NHS Workforce Statistics, February 2018 National and HEE', 22 May 2018 (for 2018, England only).

[200] Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*, 1998, p 49.

[201] For England: NHS England, 'Beds Time-series 2010–11 Onwards (Adjusted for Missing Data)', accessed 23 May 2018, overnight beds only; and for Wales: Statistics for Wales, *NHS Beds in Wales 2016–17*, 21 September 2017.

[202] Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*, 1998, p 95; and see also section 4.

mean that people spend far less time in hospital nowadays".[203] The same report suggested that bed occupancy has been "fairly stable over time", at about 85 percent.

8.4 Performance Indicators in the NHS

Since the creation of the NHS, there have been improvements in high-level indicators often used to measure health outcomes. Two such indicators are infant mortality (which the Office for Health Economics states are "often used as a measure of living standards and the effectiveness of health care provision")[204] and life expectancy.[205] Table 2 compares statistics from around the time of the inauguration of the NHS with today.

Table 2: High-level Population Health Indicators, 1940s and Present Day[206]

	1940s	Present Day
Infant mortality (Infant deaths per 1,000 live births)	61	3.7
Life expectancy—men—England	66 years	79.5 years
Life expectancy—men—Wales		78.4 years
Life expectancy—women—England	70 years	83.1 years
Life expectancy—women—Wales		82.3 years

Measures of Patient Experiences

In recent years these high-level indicators have been relatively static. Performance in the NHS now tends to be measured by a series of more detailed statistics relating to patient experiences, often relative to targets. Mostly there is no comparable data from the early days of the NHS. However, some examples are provided below.

- **Waiting lists**: in 1949 there were 498,000 patients on waiting lists in England and Wales.[207] In March 2017, the equivalent figure was 4.2 million.[208]

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[203] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018, p 46.
[204] Emma Hawe, *Sixty Years of the NHS: Changes in Demographics, Expenditure, Workforce and Family Services*, Office of Health Economics, September 2008.
[205] World Health Organisation, *An Overarching Health Indicator for the Post-2015 Development Agenda*, December 2014.
[206] Emma Hawe, *Sixty Years of the NHS: Changes in Demographics, Expenditure, Workforce and Family Services*, Office of Health Economics, September 2008 (for infant mortality, 1940, and life expectancy at birth, 1948); Office for National Statistics, 'Child Mortality in England and Wales', 14 March 2018, Table 1 (for infant mortality, 2016); and Office for National Statistics, 'Life Expectancy at Birth and at Age 65 by Local Areas, UK', 7 December 2017 (for life expectancy at birth, 2014–16).
[207] Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*, 1998, p 131.
[208] For England, NHS England, 'Consultant-led Referral to Treatment Waiting Times Data 2017–18: RTT Overview Time Series', March 2018; and for Wales, Statistics for Wales, 'NHS Wales Referral to Treatment Times: 2016–17', 13 July 2017, p 4.

- **Waiting times**: the IFS/HF have highlighted inpatient waiting times as an area of significant improvement over the last 30 years.[209] It describes how mean waiting times fell from 45 weeks in 1987, to 22 weeks by 1991. They were reduced further to around five weeks by 2010, at which point the measure was changed. In 2008, the Labour Government introduced targets such that 90 percent of inpatients and 95 percent of outpatients should be treated within 18 weeks. This target was met "consistently" until 2014. Since then performance has dropped, with the latest figures indicating 74 percent of inpatients and 89 percent of outpatients were treated within this target. However, the IFS/HF noted that "waiting times still remain very low in a historical context".[210]
- **Admissions and treatment times in accident and emergency (A&E)**: in 2017, the BBC described the NHS's then-target of treating 95 percent of A&E patients within four hours as "one of the most high profile in the health service".[211] This target was not met from the third quarter of 2014 onwards, and the latest available data from the first quarter of 2018 suggests that 85 percent were treated within four hours.[212] It was reported in some sources that the target was suspended in April 2018 until April 2019.[213]

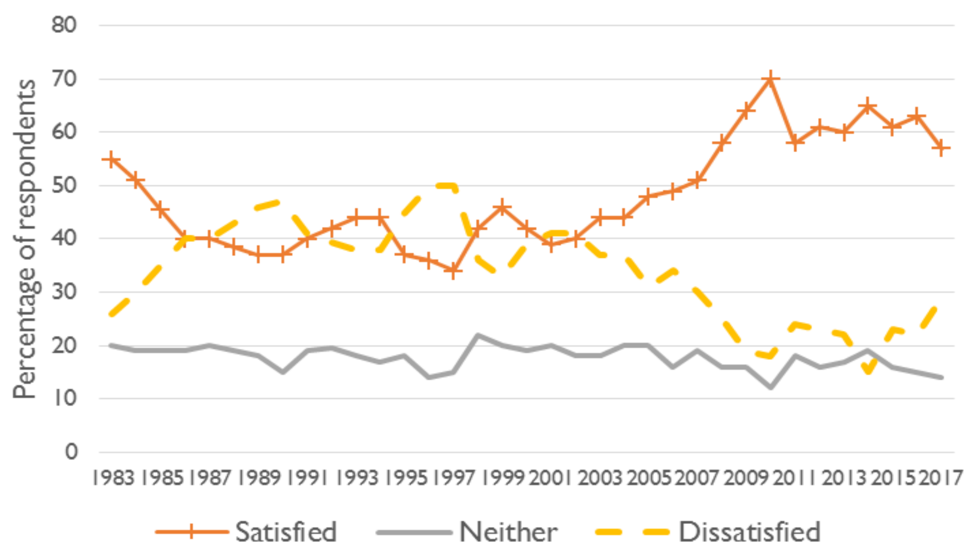
A number of other measures of patient experience in England are available from NHS England.[214]

Customer Satisfaction Surveys

Another approach to measuring NHS performance is via surveys of patient satisfaction. As the IFS/HF report stated, consistent data is available from 1983. This survey data shows falls in satisfaction during the 1980s, followed by a period in the 1990s with no clear trend. Since the turn of the millennium there has been a trend of increasing satisfaction, although with some evidence of a recent reversal.[215] The data is shown in Figure 4.

[209] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018, pp 56–7.
[210] ibid, p 57.
[211] Nick Triggle, 'Jeremy Hunt Casts Doubt on NHS's Four-hour A&E Target', BBC News, 9 January 2017.
[212] NHS England, 'A&E Attendances and Emergency Admissions 2018–19: Monthly A&E Time Series', April 2018.
[213] For example: Ian Snug, 'NHS England Suspends Four-hour A&E Targets Until April 2019', Nursing Notes, 10 April 2018.
[214] NHS England, 'Statistical Work Areas', accessed 30 May 2018.
[215] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018, pp 58–9.

Figure 4: Satisfaction with the NHS[216]



A number of other satisfaction measures are available from various sources, and the NHS Confederation has produced a summary of many of them on its website.[217]

[216] Anita Charlesworth and Paul Johnson (eds), *Securing the Future: Funding Health and Social Care to the 2030s*, Institute for Fiscal Studies and Health Foundation, May 2018, pp 58–9.
[217] NHS Confederation, 'NHS Statistics, Facts and Figures', 14 July 2017.