Crisis in the UK National Health Service

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ORIGINAL ARTICLE

Crisis in the UK National Health Service: What does it mean, and what are the consequences?

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Abstract

There have been more-or-less continual suggestions that the UK National Health Service (NHS) has been suffering from one kind of crisis or another since its creation in 1948. If we are to understand the problems the NHS faces, then we need to empirically investigate what kinds of crises it has faced, if such crises have patterns to them, and whether or not they tend to lead to policy change. This article considers NHS crisis in terms of academic accounts of its history, as well in occurrences of the term 'NHS crisis' (and its synonyms) in national newspaper headlines from the 1980s up to 2020 through the application of topic modelling. The combination of these two sources of data leads to the construction of a typology of NHS crises. Having constructed this typology, we can then examine the timing and frequency of NHS crises, and consider the relationship between crises and periods of policy change, as well as to the wider economic and social context in which crises occur through the notion of the 'NHS spatio-temporal fix'.

KEYWORDS

crisis, health policy, media, NHS, topic modelling

1 | INTRODUCTION

> It is quite important to know that virtually every day since 1948 the NHS has been said to be in crisis, and that for the last seventy-five years morale within it has never been lower.
>
> (Timmins, 2017, p. 2).

The NHS makes an excellent case study for explorations of 'crisis' in policymaking as it is clear from the Timmins quote above, there have been claims it is in 'crisis' of one kind another since its creation in 1948. This article combines methodological and empirical research to explore the concept and occurrence of NHS crises. To set up that work, it examines both academic accounts of the history of the NHS with media reports of crisis in the British National Health Service (NHS), identifying when crises have appeared, leading to the construction of a typology of crises. It then links that typology of crises with the timing of significant health reorganisation to consider the relationship between the two before finally exploring the extent to which such crises co-occur with major changes in NHS policy. It concludes by linking NHS crises with wider economic and social crises, and considers the consequences of the lack of linkage in media reporting between these different dimensions, developing the concept of different NHS 'spatio-temporal fix' designed to hold crises at bay.

To achieve its empirical analysis, it presents an innovative approach in the context of policy studies, a textual analysis approach based on topic modelling which examines all the occurrences of 'NHS crisis' (and variations of that term) in UK national media reporting in the LexisNexis news database which go back to the 1980s. This allowed us to explore the pattern and types of NHS crisis reporting increases across time, consider whether the types of crisis identified are reflected in existing academic accounts of the development of the NHS, and assess whether the reporting of crisis seems to link to periods of policy change.

The article finds 'winter crises' are the most common form NHS crisis reported in the media, but are less present in academic work, a pattern which also occurs with crises relating to diet and obesity, and for mental health crises. In contrast, academic reports of crisis in terms of both NHS reorganisation and NHS funding are far greater than those in media reporting. We also find that media reporting of NHS crises is neither necessary nor sufficient for policy change, but is more likely to be necessary than sufficient, with the exception of the 2010–12 reorganisation. This means that it takes more than a crisis for policy change to occur—but that the reporting that a crisis exists may be a key factor in securing subsequent policy change. The article concludes that the kinds of NHS crises reported in the media overlook the wider economic and social crises present in Britain, and until that link is more strongly made, it is unlikely that the NHS will be able to deal with the challenges that confront it.

The article begins with a necessarily brief exploration of the notion of crisis more broadly, before moving on to discuss its use in the context of the NHS. It then presents its method for analysing media data, followed by the 'topics' that were found in the empirical work. Finally it considers whether crises of particular types seem to be linked to periods of policy change, before presenting its conclusions.

1.1 | Crisis? What (is a) crisis?

This article's primary contribution is empirical and methodological, but it is still necessary to locate that work in relation to the wider literature in crisis. What follows is necessary partial because that literature is so large, but at the same time gives a context in which the article can be understood.

Hay (1999) states that crisis is one of the most undeveloped concepts in social and political theory, and one of the most elusive, imprecise, and generally unspecified concepts in the theoretician's armoury. It certainly seems to be the case that there are many conflicting definitions and typologies of crisis (e.g., Hermann, 1963; Rosenthal et al., 1989).

One perspective on crisis (as disaster or failure) focuses only on it as a stimulus. For example, Boin et al. (2009) present a definition which builds on the notion of crisis with its core conceptual elements of threat, urgency, and uncertainty (e.g., Rosenthal et al., 1989). On the other hand, scholars such as Hay (1996) and Jessop (2015) stress crisis involves both stimulus or problem and response. Hay (1996) regards a crisis not merely refer to a condition of rupture and breakdown, but, crucially, to a moment of decisive intervention, a moment of transformation. He continues that crisis and failure simply cannot be equated. Crisis is a moment and process of transformation. Hay (2013) states that crises should perhaps be judged as much by the transformations to which they give rise as by the

accumulation of pathologies out of which they crystallise. Jessop (2015) suggest that crises are moments of both danger and opportunity.

Crisis as a moment of opportunity (and so a necessary rather than sufficient condition for change) can be linked with two perspectives on policy change. First, Capoccia and Kelemen (2007: pp. 341, 348) define 'critical junctures' as 'brief phases of institutional flux' or 'relatively short periods of time during which there is a substantially heightened probability that agents' choices will affect the outcome of interest', explaining that these moments of fluidity are also referred to in the literature with terms such as 'turning point', 'crisis', and 'unsettled times'. (Capoccia & Kelemen, 2007, p. 341). Second, agenda-setting theories suggest that crisis can become a focusing event that facilitates policy change (Baumgartner & Jones, 1993; Birkland, 1998) by creating 'windows' of opportunity in which new approaches can be taken by policymakers (Kingdon, 2011). Hall's (1993) approach to policy paradigms locates significant policy change as a reaction to a crisis in which policymakers find their old approaches no longer working, and so have to rethink their policy instruments. As such, as well as the timing of crises, it is also important to consider their 'content'—a crisis of what?

It is important to note that much of the literature on crises links the economic to the social. O'Connor's (1973) 'fiscal crisis of the state' suggested the link between the challenges of achieving economic growth and facing social expenditure, and the problems that occur should the former no longer occur—a subject very relevant to the growth-starved 2020s. Jessop (1999, 2002) present the concept of the need to establish a 'spatio-temporal fix' between the economic and the social where the conditions of growth can be established, with social harms ameliorated through welfare programmes, but also of the continual tendency towards crises that such fixes lead to, especially under conditions of economic strain. Both these approaches link to Offe's paradox (Offe, 1984), that the state, under capitalism cannot live peacefully alongside the need to provide welfare because of the expense it occurs, but neither can it live without it because of the social consequences of unchecked economic exploitation. As such, although particular economic and social relations may cover-up this contradiction, they cannot every fully deal with them—crises can potentially appear at any time as those relations become fractured.

Crises are rarely simple in that one stimulus leads to one response (or no response). Crises have to be narrated—they have a material basis, but they do not speak for themselves (Voltolini et al., 2020) as they need to be interpreted—decisions about whether an event is a crisis, what kind of crisis it is, and how it might be resolved all have to be answered for any kind of successful policy response. (Hay, 1999). Within that context, the reporting of the media creates a key background in which crises can be either widely publicised or even over-looked should they be under-reported. This appears especially true in relation to NHS crises.

1.2 | NHS crises

As suggested above, it has been argued that the NHS has been in crisis since 1948 (Timmins, 2017). A 'Google' search for 'NHS crisis UK' gives nearly 30 M hits, many of which come from media coverage. The same search terms for 'Google Scholar' give 214,000 hits. However, there is a clear temporal trend. For example, the first decade of 1948–1958 gives 105 hits, while the last decade of 2013–2023 gives 26,200 hits. There has been much crisis language in recent years. For example, according to the Editor of the Journal of the Royal Society of Medicine:

> The NHS is in crisis. Some call it a humanitarian crisis. Others call it a political crisis. Whatever your interpretation, it's still a crisis. A crisis of funding. A crisis of bed shortages. A crisis of under provision in primary care. A crisis of crippling demand. A crisis in social care that creates a bottleneck. A crisis of flow. A crisis of common sense.
>
> (Abbasi, 2017)

Similarly, the House of Lords Inquiry (2017) states that 'the NHS has survived a long series of crises since its foundation', but then add that 'this crisis is different', although they do not explain how. However, this is a very loose definition of 'crisis', as it does not tell us the nature of the crisis or what might follow from it.

The notion of an NHS spatio-temporal fix accepts the pressures of health funding can always potentially overwhelm the resources available from the state, and suggests governments will seek compromises between levels of funding, organisational fixes that attempt to mediate between the state and interest groups such as medics or nurses, and pressures on services, but which can be overwhelmed should any of those three elements break down.

Funding levels have been a continual debate since the founding of the NHS. Organisational settlements are the source of considerable policy and political debate, and have been sites of continual contestation since the 1980s. Service pressures occur when policies and organisational forms meet the public, with the NHS historically struggling to deal (alongside other healthcare systems) with the demands put upon it. Making use of the concept of an NHS spatio-temporal fix allows us to consider how the tensions between the economic and the social are being managed (or not) in a period of health policy, and how different forms of crises might overwhelm such fixes. Specifically, NHS spatio-temporal fixes are the attempt to manage the ever-increasing demands for higher levels of funding for the service alongside political demands for the health service to 'reform' by mediating the relations of interests within health services. In Jessop's terms, there are crises *in* a spatio-temporal fix, but also crises *of* a spatio-temporal fix. There can be a variety of events that can be labelled as being an 'NHS crisis', but those events only become a crisis of when things reach a point where a response and change is required.

It is therefore important to try and understand what kinds of crisis there exist in the NHS, and when they lead to a policy change—to explore when a crisis in the NHS leads to a crisis of the NHS. With this aim in mind, we first attempted a categorisation of existing research. This search started with Klein (2013), Webster (2002) and Baggott (2015), as three widely-cited and full-length explorations of the history and politics of the NHS, and then followed citation trails from those sources as well as cross-referencing against additional searches from bibliographic databases. We then checked across bibliographic databases for articles which contained 'NHS crisis' (or synonyms) in their titles or abstracts. Once the sources had been compiled, five categories or types of crisis appeared the most common. Finally, as the article's method includes topic modelling, and as that approach is to linked to methodologically to large language models (see below), these categories of crisis were compared to those which ChatGPT 4 suggested were the most prominent—and which produced an almost perfect match, even if ChatGPT tended to present very recent sources only to support its categorisations.[1] These categories of crisis will be built upon and expanded in the media analysis and discussion sections below.

First, it is common to find referrals to a 'funding crisis' or perhaps a 'resource crisis' (around 22% of articles[2]). The NHS has historically received less funding (in almost any measure) compared to the nations the UK would typically regard as its peers, with less capital investment, fewer doctors, and less overall expenditure in comparison to healthcare systems in peer developed nations (Schneider et al., 2021). While there was a period in the 2000s which saw significant additional investment being made (Mays et al., 2011), since 2010 that investment has levelled out, and with that levelling out, rises in waiting times across a range of measures (Greener, 2018).

According to Webster (2002, pp.183–184) the Official Historian of the NHS, funding crises were recurrent in the 1980s, with Klein (2013, p.146) agreeing that period was one in which resource crisis was widespread. Funding crises were also a significant problem in the early years of the 1997 Labour government because of the perceived need of the government to show financial propriety (Webster, 2002, p. 230), a diagnosis which Klein (2013, p. 200) also largely agrees with, adding criticism of the government's unfunded commitment to reduce waiting times, and the saliency of the issue given an intervention of a prominent clinician (Klein, 2013, p. 203).

Related to, but separate from the funding crisis, is the idea of 'workforce crisis' (30% of articles). Many healthcare systems have faced protracted industrial disputes over pay and working conditions, and the NHS, especially in the 1970s and in more recent times, has not been exempt from these (Dingwall et al., 1988). At the same time, there have been repeated concerns about relatively low levels of staffing compared to other nations (with both doctors and nurses available in relation to population being relatively low (OECD, 2017)), and perhaps combined with relatively low levels of pay, leads to significant problems with pay and retention (Buchan & Seccombe, 2012). Klein (2013, p. 241) points to evidence from the mid-2000s suggesting permanent short-term management meant

that long-term strategic planning of issue such as workforce were often neglected. Baggott (2015, p. 57) agrees, linking workforce problems back to funding problems.

Third, the NHS has often attempted to deal with financial and workforce challenges, as well as criticisms of long waiting times or relatively poor health outcomes by engaging in reorganisation (e.g., Smith & Walsh, 2001). While these reorganisations have sometimes been done with the noblest of intentions and with the goal of improving health services, they have also often appeared to be motivated by political or ideological goals which have resulted in massive change for relatively little gain (Timmins, 2012). Baggott (2015) suggests that the media portrayal of the NHS as being in crisis leads to policymakers attempting organisational change when it is not needed, potentially leading to further disruption. The 1989 and 2010 reorganisations of the NHS are particularly singled out in these terms with Klein (2013, p. 258) suggesting in the latter case that the 'efficiency savings' of £20 billion required were unlikely to be achieved without significant changes to the way the NHS functioned. There is also a mismatch here in the academic literature—whereas the longer accounts of NHS history tend to present long accounts of NHS reorganisation and link to it crises, specific articles linking the two are somewhat rarer.

The fourth type of crisis is based around the challenge that, as healthcare organisations deal with life-or-death situations, they will sometimes fail. Sometimes these failings can be systemic and linked to NHS organisational structures or funding problems, and sometimes they can be the result of more local care problems or even what become called 'scandals' (Francis, 2013). The history of the NHS sadly holds a series of care failings labelled as crises either as they occurred, in or in their subsequent investigations. It is debatable as to whether these cases represent a 'crisis' or a failure or even a scandal, and the labelling of such events as the care failings at Mid-Staffordshire in the 2000s is hugely variable, making it difficult to give precise article counts. However, these events are often framed in the media especially as representing a wider crisis in the NHS, and so are included in the analysis here.

The fifth and final type of crisis often appearing in existing research is the result of sheer pressure on services. Such pressure occurs either as a result of a public health emergency (with several occurring in the time period under study here, including obesity, BSE, swine flu, but with the data not including COVID as outlined above), or often because of seasonal pressures, especially during winter, where a combination of increased demand for services combined with staff sickness results in a significant increase in waiting times and concerns that the NHS is struggling to cope. Webster (2002, p. 207) references such a crisis as occurring in 1996 as the government attempted to launch a new policy initiative to deal with challenges in this area, and another in 1998/99 (p. 231) under the New Labour government as waiting lists remained stubbornly high. Winter crisis can, of course, be linked to the other types of crises outlined above—so as a result of a lack of financial resources, workforce challenges and care failures. This kind of crisis tends to be more present in articles than in the books outlined above (around 15% of all types of article).

Some accounts of NHS crisis make links to the more general work on crisis which appeared earlier in the article. Klein (2013, p.166–167) links public health policy to Hall's (1993) policy paradigms framework, suggesting the new approach taken by the Conservative government in the early 1990s as it took a greater interest in the wider determinants of health (in contrast to the more individualistic approach of the 1980s), represents a policy paradigm shift, but not perhaps one which was preceded by an obvious crisis, perhaps making his usage more metaphorical than a direct application of the framework. However, the increase in inequality since that period suggests that Klein's analysis in this specific example might have been premature. Greener (2002) and Powell (2016) also explore the use of Hall's framework in relation to the NHS, applying the ideas in a more systematic way, but largely absent from either account is an exploration of the role of crisis as provoking a large-scale 'paradigmatic' change.

As such, although there is work in health policy and the NHS that makes use of frameworks which incorporate the idea of crisis as a key driver of policy change, existing use of those frameworks is not often systematically linked to events in the history of the NHS that have been labelled as representing 'crises'. These accounts of crisis are also not generally linked to wider economic and social crises except as an exogenous driver of change—with the clearest

example coming during the 1970s as a result of the economic shocks and resulting political challenges that subsequently appeared. It is also the case that existing accounts of health policy are primarily qualitative in nature, being rich, detailed explorations, but leaving open the question of how their analysis might be more replicable. How might we bring these different aspects of research together in a rigorous manner?

2 | NEWSPAPER REPORTS OF NHS CRISIS AND TOPIC MODELLING

It is possible to try and measure the occurrence of crisis in a number of ways (and we have already included some article counts above as a starting point). One approach might be to look at quantitative measures of health system performance such as waiting times or reported financial deficits, and attempt to set thresholds beyond which a crisis might have occurred. This is an entirely valid approach, and would tie in with some of the types of crisis outlined in the earlier sections. However, this would lead to the construction of a complex model the generalisability of which from one period to another is likely to be debatable, and when perhaps a more straightforward approach can be taken. This article instead examines the reporting of NHS crisis in national newspapers. Although media reporting will clearly never capture the complexity of the situation in such a diverse organisation as the NHS, the media is clearly a key mediator in the process of interpreting whether a public service is facing crisis, as well as categorising the kind of crisis being experienced, as well as gauging what (if anything) ought to be done in response.

The data was gathered by searching the full national newspaper database of LexisNexis news for the occurrence of 'NHS crisis' (or a range of synonyms) in the headline or first paragraph from the beginning of the database (broadly the mid-1980s) through to the end of 2019 (to avoid the additional complications of dealing with reporting of the pandemic). The headline and first paragraph were chosen in order to try and ensure that the story was primarily concerned with NHS crisis, as the generally accepted story structure of newspapers is to lead with the most salient topics in early sections. National newspapers were chosen in order to find stories that had gone beyond local boundaries or services.

Once the data had been collected, it was imported into R through the use of 'LexisNexisTools'[3] package, cleaned, and then topic modelling applied to it. Topic modelling is an approach to data analysis which treats each story as a 'bag of words', attempting to capture its core dimensions in terms of the occurrence of words, and to look for other stories that have similar patterns of such occurrences (van Atteveldt et al., 2021). This approach is very new in the context of social policy—indeed we can find only three other articles attempting it (Baranowski et al., 2023; Goyal & Howlett, 2021; Gülzau, 2020), with the latter being closest to this article because of its shared concern with newspaper articles, however this article goes somewhat further than that piece in linking its analysis both to academic articles, and linking its discussion to economic, social and policy change.

Topic modelling does not explain in any case what the topics found in the data actually represent—this requires an analyst to look at the word patterns found by the models, to read the stories allocated to the topic, and then to interpret what each topic represents. Some of the topics in the analysis below are not relevant to the article in that the stories mentioned health crises in passing rather than the story being substantively concerned with a discussion of a particular NHS problem.

A key challenge in topic modelling is deciding the number of topics the algorithm should look for in the data. This was achieved by examining measures of topic coherence and by running models several times on training data before being further assessed on their performance against the 'held-out' or remaining data to ensure the models were not over-fitted (Blei et al., 2003). Topic modelling for the article was carried out with the 'stm' package in R,[4] and which has a function (searchK) which examines the performance of topic modelling against a range of topic number values, and allowing a candidate numbers of topics to be selected. Those candidate numbers of topics were then run as full models, and the best-performing one in terms of the interpretability and measured robustness of its results, and which was based around nine topics, is reported below.

3 | RESULTS

After working through the search patterns outlined above, comprising of 9758 articles comprising of 2,664,387 tokens, or words that are present in each individual article, but might occur several times in that article.

A first step is to examine the pattern of mentions of NHS crises in national newspaper coverage to get a sense of their extent and timing. That produces the following chart:

The chart above seems to show an increase before 1990, followed by a significant rise around 2000, another towards the middle of the decade, and then a general rise in media stories from around 2012, with some dramatic peaks in particular months. Digging into the data further allows us to begin to interrogate those patterns.

3.1 | Topic modelling results

According to the diagnostics outlined in the methods section, combined with the authors examining the outputs of those models, a nine topic model appeared to provide the most robust fit for the data in the sample.

Although topic modelling produces statistical relationships, there is no guarantee that those results will be substantively important as well. After an inspection of the top-scoring documents for each topic, topic 1 was found to be concerned with a more general sense of crisis in UK politics (especially related to Brexit) in which the NHS was often mentioned, and topic 4 contained articles based around the 2007/8 financial crisis and its implications for the NHS—and which might be regarded as an exogenous shock to healthcare, but with the discussion being mostly around financial rather than health crisis. However, the link between general economic and social crisis and the NHS will be something to which the article will return below. Topic 6 (the smallest of the topics in terms of article frequency) appeared to be made up of lifestyle articles which had little link to the health system as a whole. As such, although these topics were coherent empirically, their content will not be discussed in depth below as they are important in terms of being statistically significant, but not substantively important to the particular questions this article aimed to answer.

The six topics that remained, along with their frequency, are presented in Table 1 below.

We can further plot the dates of occurrence of the 'winter crisis' articles—the most frequently found topic in the data, with the following result:

Figure 1 suggests we can see the general incidence of concern about winter crisis hitting peaks around 2000, then again in 2005, and again from 2013 onwards were they become more prevalent.

TABLE 1 The six substantive topics found in the media analysis.

| Topic	Articles	Subject	Narrative
Topic 5	2363	Winter crises	The pressure on winter services is overwhelming the NHS
Topic 2	1463	Staffing recruitment crises, especially for nurses	The NHS has too few staff because of poor planning and/or inability to recruit and retain
Topic 9	979	Patient safety crises, especially in relation to hospital infections	There are problems with patient care and/or specific examples of care failure
Topic 8	925	Diet and obesity crises, related to sugar and dental health	Obesity rates are growing and this is putting excessive demand on health services
Topic 7	786	Mental health crises	The NHS lacks sufficient capacity to treat mental illness well
Topic 3	684	Social care and housing crises	Social care and/or housing is poorly integrated with the NHS and often under-funded and under-resourced
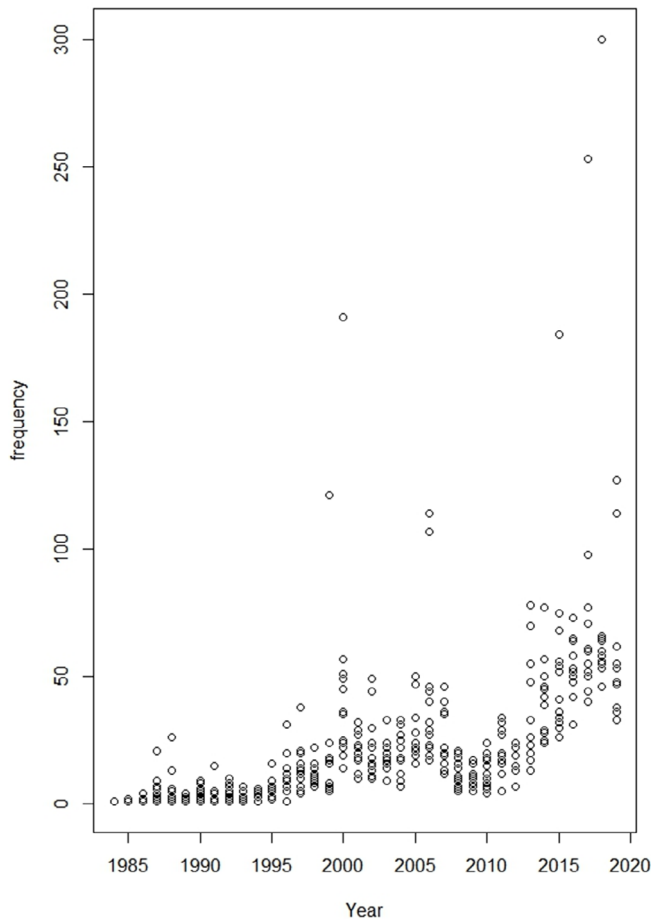
FIGURE 1 Media reporting of winter crises by date.

If topic 5 is heavily concerned with winter crises, topic 2 is mostly concerned with recruitment and staffing crises of different kinds, especially for nurses, and often with articles concerned with the staffing situation in Scotland. Topic 9 is concerned with hospital infections and overlaps with topic one to the extent that these are often linked to high usage of hospitals and are also linked to topic two because of concerns about shortages of staff making care less safe than it might be. The highest-occurring month by far for that topic is again January (280 mentions), again linking the prevalence of these stories to the winter period.

Topic 8 is concerned with the link between diet and obesity, especially in relation to sugar, and is often related to concerns about dentistry. Once again, January is the peak month for reporting of this topic (115 articles). There is less intrinsic reason why this topic should be reported in these months as such challenges are not unique to the winter months. However, it would seem that while reporting other types of NHS crisis, stories in this topic are also more likely to be reported.

Topic 7 (mental health) does not follow the pattern of monthly publication of the other topics here. The highest reporting months for this topic, which is predominantly concerned with a range of challenges around mental health is July (86) followed by November (84), October (76) and May (74). In December and January there is actually a fall-off of stories concerned with mental health (59 and 58 articles), perhaps as coverage of this topic is 'crowded-out' by winter crises, with other forms of crises presented as being more urgent in those months.

Finally, topic 3 is concerned with social care and housing and the relation between those services and health. The peak of this coverage again occurs across the winter months, which given the climate of the UK and the increased risks to people (especially the elderly) when the weather is cold, is not surprising.

4 | DISCUSSION

This section compares the relationship between the types of crises identified in the literature review and those present in the media empirical data, seeking reasons for differences. It then moves on to consider the nature of the relationship between crises and NHS policy change in greater depth.

The first type of NHS crisis in the academic literature was concerned with funding, and this is present in the empirical data, but proved to be difficult to separate from more general discussions about financial problems in the wider economy. These discussions appeared most obviously in topic 4 which was not outlined in the previous section as many of the articles, although they did mention the funding crisis in the NHS, were not specifically about healthcare funding crisis. Although there are many articles mentioning NHS finance and funding, relatively few are specifically concerned with it, preferring instead to locate the discussion in wider accounts of the economy. There is little specific, careful, empirical discussion about the challenges of funding the NHS, creating a context in which it is generally not well-understood in the public that for most of its history, the NHS has been among the lowest-funded health systems among its peers (Ipsos, 2012). That there is so little careful, detailed exploration of NHS funding levels in the media has to be a source of concern in terms of the quality of public debate around health services in the context of such significant public misunderstanding. This is an important insight that will be returned to in the conclusion below.

The second type of crisis reported in the literature review was workforce crisis, and this clearly appears in the data in terms of topic 2. The most reported group experiencing workforce crisis in the data are nurses, which is relatively unsurprising given that nursing is the largest professional group in the NHS, but as the 2010s develop doctors become increasingly mentioned, especially in relation to the industrial disputes, not least in terms of the dispute with junior doctors in that period. Workforce crises are therefore well-represented in both academic and media data.

The third type of crisis in the literature review related to NHS reorganisation. The relationship to the media empirical data here is not as obvious—reorganisation is something less-reported in the media directly, but instead the reasons for reorganisation have greater prominence—especially in terms of waiting times (topic 5) and care failure (topic 9). There appears to be a difference between what academic research finds important (the politics and details of reorganisation), and what is discussed in the general media (the problems the NHS is experiencing in terms of the stories reported about it). This may be related to discussions around funding crises outlined above as both topics are complex to communicate in the shorter form of newspaper articles. Although both a lack of funding and the way the NHS is organised are crucial to understanding the challenges the NHS is facing, they are both one step removed from the consequences of getting either or both wrong, and so may be of less intrinsic interest to the public than stories about the consequences of winter crisis or understaffing.

The fourth type of crisis, care failure, is clearly linked to topic 9 (patient safety), with hospital acquired infections (MRSA, bug, and superbug) and the consequences of waiting (often in corridors or other non-care locations) appearing as key words, and is clearly illustrated by the stories reported within the topic. These kinds of stories often have personal stories attached, without linkages to wider challenges such as lack of funding. It can be argued that these events represent failures or 'scandals' more than NHS crises, but they are reported as representing crises, and given the ability of the media to shape debates around health services, it is therefore worth exploring them in that light.

Finally, the fifth type of crisis—that linked to pressure on services—is most linked to the most prevalent type of crisis reported in the media—winter crisis. There are a number of dimensions in the media stories, with discussions about missed targets, human interest stories on cancelled operations, with coverage often linked to specific politicians trying to resolve the challenge before them. This type of crisis is by far the one most frequently reported in the media, but does not appear with the same frequency academic accounts of the history of the NHS. There is clear

evidence, however, that both academic article and such media reporting of winter crisis has grown significantly, with spikes in such reporting in the late 2000s, and from 2015 onwards, with this latter period especially linked to the rises in waiting times reported in services that pre-dated the pandemic (as well as being further exacerbated by it). As noted above, it has also become a key topic of research for organisations such as the King's Fund.

If funding, workforce and care failure crises are very present in the data (but reorganisation crises less so), then there other types of crises more present in the media data than in academic accounts of NHS crises. It is worth reflecting on each of these, and why they might be relatively under-represented in academic accounts.

Topic 8 in the data was about diet and obesity. Increasing obesity rates and the challenges they bring to service provision are often covered in histories of the NHS, but less often presented as a crisis in themselves. Baggott (2015, p. 108), comes close to suggesting that to label obesity in this way is an example of the media manufacturing a crisis. Klein (2013, p. 315) labels obesity as representing an epidemic (alongside cancer and cardiovascular disease), but only mentions policy attempting to address it in passing. It is hard to find any mention of obesity or diet in Webster's (2002) account.

One reason for this lack of emphasis on diet and obesity is the more political focus of longer accounts of the history and development of the NHS, but also that obesity is a political as well as personal issue, with the food and drinks industry often making significant political donations and sponsoring major social and sporting events. Whereas other crises tend to have more obvious triggers, the change in diets and its implications for our health has been a longer-term problem (Kelly, 2018). In this sense it does not have the single trigger or focussing event that other crises tend to—but the scale of the challenge and the extent of reporting of it surely warrants use of that term, and for those writing about NHS policy and politics to take greater notice of this challenge.

Topic 7 in the data was broadly concerned with rising concerns around mental health. This area is also not central to the accounts of either Klein or Webster, except in terms of outlining how mental health services fit into NHS organisational structures, but does play a more central role in Baggott (2015, p.100, p.107), who discusses mental health especially in relation to media coverage and the stigma of negative portrayals of people with poor mental health, but also how it can have a positive effect in raising awareness in more positive portrayals (Baggott, 2015, p.105). Baggott also discusses the importance of patient groups in lobbying for improvements in service provision in mental health (Baggott, 2015, pp. 138–139). However, it remains the case that mental health is not labelled as a 'crisis' or as having the same degree of urgency as other areas of policy. In terms of articles, mental health represents around 14% of the articles found on crisis, so is certainly present in those accounts, but less so than financial, workforce, or winter and other service crisis types.

One reason for the mental health being given less priority in longer accounts is historical—mental health services have been given less prominence than those for physical health, and it is still relatively recent that anything approaching equal parity has been suggested (Baggott, 2015, p 86). Mental health problems have often been less discussed and less debated than those for physical health (Baggott, 2015, p. 16). and it might genuinely be that the media are leading policy and politics academics in opening up this area to greater debate. The majority of articles concerned with mental health appear in the last 15 years or so, indicating an increase in academic attention, but one still proportionately less than appears in the media reporting.

The final area less reported as being a crisis in policy and politics work is that of social care. However, what we now call social care has been explored in relation to 'community health' and under a variety of different names which reflect the individual services within it ('elderly care', 'children in care') and so it can be hard to see the range of services as representing a single area in studies of policy. Whereas these individual services are often narrated in accounts of the development of the NHS, they are not generally labelled as being in 'crisis'. As such, as well as being perhaps even more diverse than NHS services, social care services are often located organizationally separate from those in the NHS, as many are funded and provided through local government, or contracted by local government and provided by the not-for-profit and private sector. This makes it even harder to understand the challenges faced by those services as a whole.

4.1 | NHS crises and policy change

Exploring whether the rises in concern in NHS crisis can be linked to significant NHS policy change brings a range of difficulties—defining what exactly counts as a significant policy change is a question about which perhaps work deriving from Hall's (1993) 'policy paradigm's framework has been most clear about as it requires the differentiation between different orders of change. It is also the case that, in the period covered by the empirical data, there have been periods of continual policy change, especially during the early 2000s (Smith & Walsh, 2001).

In addition to the challenge of identifying significant policy change, there are also problems in claiming causality in that a particular crisis led to a particular change without bringing in detailed process-tracing work (see George & Bennett, 2005). There are also likely to be significant lags between crises and policy change, especially when those crises might have led to government inquiries. Finally, crises in funding might well result in subsequent funding increases, but whether the latter represents a significant policy change will depend on whether such funding represents a longer-term commitment (as appears to have been the case with the Labour from 2002 (Wanless, 2002), or something more temporary.

By triangulating the accounts of academic writers from which the general themes of types of NHS crises were gathered, there is however some consensus of particular periods of policy change being important. In the late 1980s there was a period of debate leading to the introduction of the first 'internal market' in the 1990s; around 2000, there was the introduction of the NHS Plan, after 2002 there was the pledge to increase NHS funding, and then in 2010–2012 there were a range of controversial organisational changes introduced under the coalition government, along with a reduction in the rate of increase in funding for the NHS. Although there were a range of other policy initiatives throughout that period, those seem to be the largest top-level policy changes. Each can be considered as an attempt to put in place a new NHS spatio-temporal fix by policymakers.

Historically, the NHS up to the 1980s was characterised by being funded at comparatively low levels, but offering doctors especially high levels of autonomy and discretion and with implicit rationing in place to conceal the struggle to cope with the demands placed upon the service (Klein, 2013). However, the poor funding settlements offered to the NHS in the 1980s, combined with increased demands from patients and rising service pressures, led to the attempt by the Conservative government to find another spatio-temporal fix to deal with the sense of crisis that seemed to confront them. In her own account of the pressures that led to the 'internal market' reorganisation, Thatcher explicitly links the motivation for those changes to be borne of financial pressures and the criticisms her government were receiving of its handling of the NHS (Thatcher, 1993, pp.606–617). The internal market reorganisation, at the surface, put in place a market-based structure that created greater space to challenge medical expertise from both patients and managers, and so allowed the government to be able to claim to have 'reformed' the service on more market lines. However, the extent of these changes is open to significant dispute (Klein, 1998). In retrospect, it was perhaps the increase in NHS funding at the beginning of the 1990s, rather than the internal market, that allowed the NHS to overcome its immediate crisis, even if the funding increase did not last long.[5]

After Labour's election in 1997, waiting list crises emerged again, and the NHS Plan of 2000 was explicitly positioned as a response to Labour's concerns about it losing ground on waiting, which was a key area where it had made promises in the 1997 General Election and needed to show progress (Giddens, 2002). Labour's new fix was to offer higher levels of funding, but only if the NHS 'reformed', and with the demands for an increased marketization even greater than those of the 1990s (Mays et al., 2011) Both the internal market and the NHS Plan, then, saw an increase in NHS funding.[6] In Jessop's terms, they were an acknowledgement that a new spatio-temporal fix for healthcare was required, and although the total reorganisation package included many dimensions, it appears in retrospect that the increase in funding that resulted was the most significant element in the mix in terms of overcoming the challenges the NHS was experiencing at the time. The more sustained increases in funding in the 2000s, however, can be linked to improvements in a variety of health outcome measures during that decade (Greener, 2018). It is certainly arguable, however, that both reorganisations led to a reduction in the power of the medical profession in health services (Harrison, 2002)—but that this was a gradual process as performance management, budget setting and medical contracts and accountability gradually reduced doctor autonomy.

In the 2000s there appear to be short duration but prominent spikes in crisis reporting building to a substantial rise around 2007 before a sustained rise after 2012—which is the period after the introduction of the coalition government's NHS reorganisation. The 2012 reorganisation is especially significant as it occurred at a time when there was comparatively little sense of crisis. As such, it seems to represent an example more of 'garbage can' policymaking in being a reorganisation in search of a problem, and perhaps designed more to please the government's supporters than to address a particular problem (Timmins, 2012). After 2012, crisis reporting as we can see from Figure 2, becomes far more widespread, however, there has been no significant reorganisation of the NHS since then. It also appears that at least some of the health outcome gains of the 2000s have been lost (Ruckers & Labonte, 2017). It is also noticeable that there has not been a significant attempt to come up with a new funding or organisational settlement since that period—something to which the article will return in the conclusion below.

This exploration allows us to some conclusions about the relationship between crisis and policy change in the NHS. First, NHS crises are neither necessary nor sufficient for policy change. They are not sufficient as every period of crisis does not lead to policy change—that is most clear in the case in the rise of reports of crisis around 2007 (which were often associated with the wider financial crisis), and from 2015 onwards. Equally, an NHS crisis is not necessary (in itself) for policy change—the 2010–2012 reorganisation occurred at a time when concerns about crisis were at their lowest for some time.
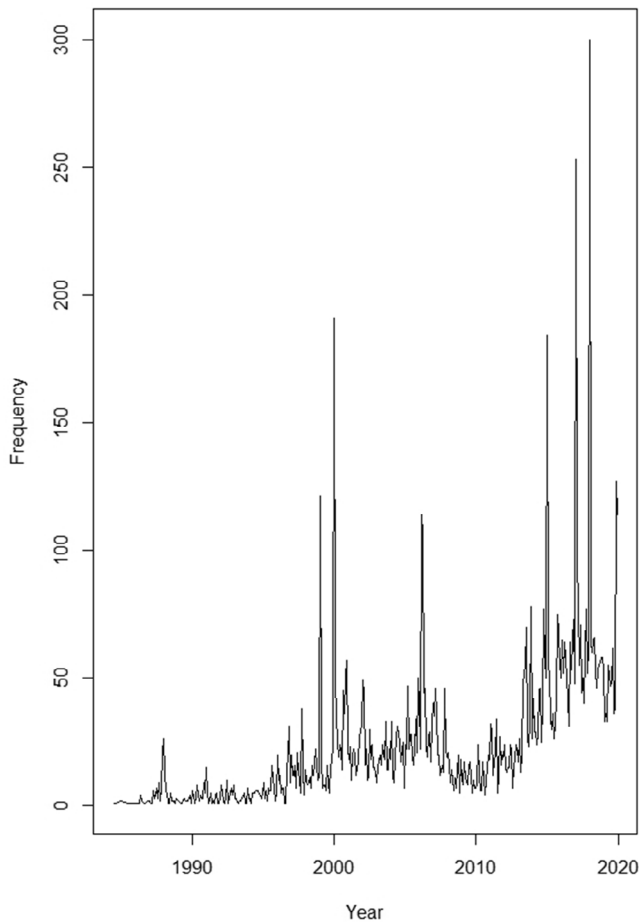

FIGURE 2 Occurrence of 'NHS crisis' in national media reporting in LexisNexis news.

It is perhaps more accurate to say that NHS crises are more necessary than sufficient in that significant periods of policy change are more often than not preceded by a crisis of some kind or another (e.g., late 1980s, around 2000 and in the early 2000s), but as we have seen, not all crises lead to policy change, and not all policy change requires a crisis. Working out what additional factors need to be needed might be inherently contextual—the reasons given for the introduction of the first internal market in the late 1980s were very different than those given for the introduction of the NHS Plan, despite the fix they offered, as it turned out, perhaps being most powerful in terms of the funding increase they put in place. Crisis can act as a focussing event that suggests change may be needed, but whether that event turns into a demand for policy change requires that government acknowledges a problem, and is willing and able to respond to it. Since 2015 calls for crisis have not resulted in significant policy change—possibly as a result of the time and energy spent defending the 2012 reorganisation which appears to have been largely unneeded, and perhaps also because of the increase in funding that such changes might require.

It also appears that there isn't a particular type of NHS crisis that is more likely to lead to policy change. In the period post-2015, the most reported form of crisis, winter crisis, have increased dramatically, but across the board media reporting of NHS crises of all kinds has increased –without a significant policy response.

5 | CONCLUSION

This article has utilised innovative methods to explore the topic if crisis in relation to the NHS. The application of topic modelling allows a rigorous and replicable analysis of media context to be included in the article, dealing with a volume of data that would be difficult to include if it were to be analysed by hand, as well as for the latent as well as manifest characteristics of that data to be analysed.

A first finding is that it is clear that the NHS was in crisis well before the pandemic began in 2020. The rise in reporting of health crises rises from 2012 onwards, and is especially linked in the data to the challenges the NHS has faced in relation to providing health services in winter, but this insight links to wider rises in waiting times in the service.

It is undoubtedly the case that NHS crises form a key part of explanations of health policy change, but there is not always a direct link between the two. NHS crises do not always lead to policy change, but it is more likely that significant policy change is often preceded by an NHS crisis of one kind or another with one exception—the reorganisation of 2010–2012. If crisis does not always lead to change, then it is not always a 'turning-point', but it still makes sense to use the language of crisis to explore the situation where service pressures grow to the extent that they are at risk of failure. However, winter crises have become so regular and perhaps now so expected, that they may have lost their power in driving policy change. In this sense, they are no longer focusing events—they command significant media attention, but policymakers appear to have learned that is not necessary to respond to them. Indeed, as this article is being finalised (December 2023) even the Shadow Secretary of State for Health is being widely reported as saying the NHS is using winter crises as an excuse to ask for greater funding.

Crises can represent a moment of reckoning or the accumulation of smaller challenges until such strain or pressure is reached that levels of concern cross a threshold. Winter crises, up to 2010, represented the first kind, whereas diet and obesity and mental health appear to represent the second. We might suggest that it is less likely that the second type of crisis would provoke an urgent policy response (as the problem has been gradually growing over a longer period of time), but in recent years it has also become less likely that the former kind of crisis has provoked a clear response either—perhaps as a result of the fallout from the 2010–2012 reorganisation, perhaps as a symptom of a lack of a new NHS spatio-temporal fix being seen as possible. As such, 'crisis' in the NHS, even before the pandemic, seemed no longer to represent a turning point or prompt for change, but simply the status quo, and given the lack of connection often made in those discussions to levels of funding, there are real concerns about the extent to which media reporting may be representing the root of the problems the NHS faces.

The consequence of the analysis above can be drawn out further. Since 2008, the situation in the UK has more closely resembled that of the early 1980s, where it seemed clear a period of sustained growth had come to an end,

and public service 'retrenchment' was deemed necessary (Pierson, 2006). Similarly, in 2010, the coalition government presented a programme based on the management of 'austerity' (Blyth, 2015), but such an approach has had significant consequences for health both before (Ruckers & Labonte, 2017) and during the pandemic (Williams et al., 2021).

The lack of linkage between NHS crises and the wider economic and social problems in media coverage in the UK limits the framing of such crises to being ones that internal to the health system, when many of the causes of those problems are far wider. The NHS did not experience winter crises to anything like the same extent in the second half of the first decade of the twenty-first century (Greener, 2018), which was also the period in which it received significant increases in funding that brought its level closer to those of comparative industrial nations. Those increases in funding fell off after 2010—which is the time that the rise in waiting times began again.[7] Looking wider, the NHS is perhaps best seen as a barometer of a wider economic and social crisis in the UK—something that has been long-acknowledged as being the case (Klein, 1983). The Equality Trust estimate the UK's levels of inequality cost around £40bn a year in terms of physical health, £70 bn a year in terms of mental health—and comprise the two greatest costs of inequality in Britain (The Equality Trust, 2023). It is significant that two of the less-reported categories of NHS crisis—diet and mental health—form a substantial part of those total costs of inequality, and the lack of link between wider economic and social forces and NHS crises in media reporting present a significant problem in the framing of the crises in healthcare.

What this suggests is that NHS crises have to be considered not on their own terms, but as symptoms of a wider economic and social ill. Over 40 years ago, Klein (1983) suggested that the NHS had been remarkably successful in terms of achieving equity (if we ignore the ability of the middle classes to achieve better access to services than they ought to), but that the crisis of the NHS was in fact a 'wider social crisis, reflecting uncertainty about the appropriate boundaries between public and private provision of welfare, about the power of professionals and bureaucrats and the limits of altruistic social policies in an age of economic austerity' (p. 214). Looking back over the time since then, much of which is reflected in the topic modelling data in the article, we can see attempts at resolving these crises in the 1990s (with the internal market reorganisations) and in the 2000s (with the NHS Plan and abortive expansions of private provision). In Jessop's terms, these were attempts to achieve new spatio-temporal fixes in health policy, with attempts at reorganising the NHS to incentivise organisations measured as being successful—especially through a more consumerist, choice-driven lens (Bate & Robert, 2006). Such fixes, however, depended on the availability of increased funding, as well as demand for services not further increasing beyond health service's capacity. Since 2010 the slowdown in increases of sums available to the NHS, combined with the widening economic and social problems facing the UK, have been key drivers of the rise in reporting of crises of all kinds in the NHS, but with that reporting increasingly disconnected from the underlying causes of those crises. This suggests that there is an urgent need to challenge the way that the current crises are being narrated to include those wider economic and social causes, or to accept the 'inadequacy' which Klein suggests risks pervading both the NHS and wider British society. Only by considering healthcare in this wider sense can an NHS spatio-temporal fix be found which has a chance of addressing the challenges which healthcare in the UK actually faces.

There is clearly scope for further work—in exploring in a more detailed way the link between economic and social crisis and health crisis, between crisis and policy change more generally, as well as to extend the research past 2019, and so to incorporate the pandemic. However, it may take years before the full effects of COVID 19 can be taken into account. It would also be interesting to widen the scope of data beyond media reporting to include other sources, such as medical journals or web-only news, such as the BBC news website, and to see if similar patterns appear in that data as well.

DATA AVAILABILITY STATEMENT

I am happy to make all R coding available, but the data might be a problem as it is massive and would be difficult to upload.

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ENDNOTES

[1] The ChatGPT prompts and responses are included in an online appendix.

[2] A list of article counts is included in an online appendix.

[3] Available at https://cran.r-project.org/web/packages/LexisNexisTools/index.html.

[4] Available at https://cran.r-project.org/web/packages/stm/index.html.

[5] Attempting to measure changes in NHS funding is notoriously difficult, but the increase in NHS expenditure as a proportion of GDP was 7.8% in 1991 and 8.2% in 1992, compared to the mean rise 1980–2019 of 1.8% and median of 1.1% (all figures from OECD health statistics—https://data.oecd.org/healthres/health-spending.htm.

[6] The increase in 2001 and 2002—the 2 years after the NHS Plan, was 4.5% and 5.5%, so still very much about the mean and median figures.

[7] See the longitudinal data collection from the King's Fund at https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/waiting-times#waiting-times.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.