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David Ebhomielen
Lehigh University

NATIONAL HEALTH SERVICE ENGLAND: AN OVERVIEW AND ANALYSIS OF CHALLENGES

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In a 2017 study, the UK National Health Service (NHS) was ranked as the highest performing health system when compared with those in ten other wealthy nations. However, protests in England tell a different story. As NHS staff in England cope with rising demands amid insufficient funding, accident and emergency services wait times are increasing and hospitals' safety ratings are falling. This article examines the strengths and challenges facing England's NHS and suggests recommendations to prevent its potential collapse.

Introduction

The UK National Health Service (NHS) is considered one of the most reputable health care systems in the world. Its exemplary performance can be attributed to its core values: it is free at the point of access; it meets the needs of everyone; and it is based on need, not ability to pay ("The Principles…"). However, the translation of these values to practical policy has proved difficult in the last decade, resulting in problems such as longer wait times, overcrowded lobbies, and hospitals closing. According to the Care Quality Commission (CQC), a monitoring board inspecting financial stability and safety of care, 54% of acute hospitals in England were rated as requiring improvement or as inadequate in 2016/2017 ("The State of Health…"). The NHS in England hit its lowest point with the Mid Staffordshire scandal, when between 400 and 1,200 patients died as a result of poor care between 2005 and 2009 (Campbell, "Mid Staffs…"). "Crisis," "catastrophe," and "breaking point" have all been used to describe the NHS England in the media. Yet statistics show a less horrific reality. In this article, I discuss the challenges of England's NHS specifically and their underlying causes. I begin by presenting the history and current structure of the system. Next, I outline its strengths and shortcomings and offer recommendations of my own. Finally, I conclude that the NHS in England has its strengths but is still facing challenges that, if unaddressed, could lead to a breakdown of the system.

NHS History

Britain Before the NHS

The establishment of the NHS in 1948 came after several decades of discussion on how to provide health care in the UK. Ultimately, the casualties of World War II served as a catalyst for change. Prior to the NHS, British

citizens were under a patchwork health system. Pre–World War II, the British had three ways to obtain health care: 1) employment funds, which were primarily available to men; 2) the private sector, which only the rich could afford; and 3) the Poor Law, for the poorest. This structure resulted in approximately 40% of the UK being insured (Timmons).

Employment funds were a system built for the working citizen earning below a certain level of income, where both employee and employer contributed a small fee to the government. In exchange, individuals were allowed free but limited access to hospitals (Berridge). Alternatively, in the private sector, health care providers were paid out of pocket at the point of treatment by simply relying on individual finances. Doctors sometimes helped poorer patients by waiving the fee completely. Lastly, the Poor Law Amendment Act of 1834 was for the most desperate of people. The poor would labor in workhouses, performing rudimentary yet cruel work, often in deplorable conditions, to ensure they received treatment when ill ("History: People and Poverty").

The casualties and devastation of World War II were pivotal in spurring the government to amend many aspects of society, including health care. Sir William Beveridge emphasized the need for change in the Beveridge Report (1942), but he gave only a brief explanation on how the new social health service would be funded. It was Aneurin Bevan, a Welsh Labour Party politician and Minister of Health from 1945 to 1951, who presented the actual framework for the National Health Service Act of 1946.

Creation of the NHS, the Internal Market, and the New Labour System

When it was launched by Bevan, the NHS was founded on three core principles: it would meet the needs of everyone, provide services free at the point of delivery, and be based on clinical need, not ability to pay ("The Principles…"). The NHS came into effect on July 5, 1948, guaranteeing everyone medical treatment when needed and at no cost.[1] This assurance was made possible by general taxation, including income taxes, value-added taxes, and National Insurance contributions. The new service covered the three branches of health care: hospital services, community health services, and primary care (Rivett). As Minister of Health, Bevan established regional boards, local health authorities, committees, and councils as regulators to monitor the decision making within these prongs. General practitioners (GPs) and dentists were considered private contractors to the NHS and they were on a standard salary, not paid per service.

Despite all these positive changes established by the NHS, problems emerged. Initially, when the NHS bill was brought to Parliament in 1946, the annual cost was projected to be £110 million. This budget was quickly increased as the years passed, and by 1951, the actual cost was £384 million (Rivett). The cost kept increasing and the Conservatives grew more indignant toward Bevan's Labour Party. When Labour lost the general election to the Conservatives in 1951, the new party in power imposed a five-pence prescription charge in an attempt to reduce expenditure (Rivett). Over the next few decades, the NHS produced increasingly positive results as new drugs were introduced, and more health centers were built to keep the public healthy. Drugs for more complex diseases, however, such as cancer and AIDS, increased costs.

In 1990 the NHS underwent its largest reform yet through the National Health Service and Community Care Act. The bill introduced the "internal market," meaning that local health authorities and GPs were now responsible for managing their own budgets (provided by the Department of Health) while making contracts with other health providers ("History of the NHS"). The Conservative government presented the internal market as a solution, although controversially, to the problem of growing waiting lists. They hoped that introducing this type of competition among NHS trusts (independent organizations providing several medicine-related services) would urge them to provide better quality

[1]The UK NHS comprises 4 branches: Health and Social Care in Northern Ireland, NHS England, NHS Scotland, and NHS Wales. The specifics of this article refer to NHS England.

care more quickly ("History of the NHS"). An analysis done by the King's Fund (a charity involved with shaping health policy and practice in England) concluded that the "reforms had largely failed to live up to the claims of their proponents and the fears of their critics, principally because the incentives of the internal market were too weak, and the constraints imposed too strong" (Mays). After almost a decade of adjustments, the new government sought to make changes.

The English Labour party reformed its internal market in the NHS Plan 2000, leading to a period in NHS history from 2000 to 2007 guided by this plan. The key elements that categorized this era were the creation of foundation trusts (providers similar to NHS trusts but with more local responsibility and authority), implementation of payment by results, emphasis on patient choice, and inclusion of the private sector among providers the NHS covered. This New Labour system, most importantly, was marked by a continual increase in funds (Rivett).

To develop a more quality-based NHS, payment by results was introduced to give hospitals greater incentive to improve patients' health. Hospitals would receive payment only for services performed as opposed to block contracts (a set amount given at the start of every year). Thus, hospitals ventured to generate more revenue by attracting more patients who exercised their patient choice (Dragoonis). These reforms were designed to create an NHS with higher quality, improved responsiveness, greater equity of access, and better value for money (Mays). However, the effects of the 2000 reforms were slower and less significant than hoped. Ultimately, the financial crisis of 2007/2008 throttled funding increases and provided the impetus for the Health and Social Care Act passed in 2012.

2012 Reforms

The 2012 reforms laid out a plan for several complicated changes. The most significant reform was the creation of NHS England. Its primary role is to determine the priorities and direction of the NHS and to ameliorate health care quality and outcomes for those in England. Most of the budget NHS England receives from the Department of Health goes directly to Clinical Commissioning Groups (CCGs). The 207 CCGs in England consist primarily of GPs, public health practitioners, and other medical practitioners including nurses and hospital doctors. They are tasked with improving the health of their local population by choosing and buying the services from hospitals, community services, and private and voluntary sectors.

NHS Improvement and the CQC are bodies created to monitor finances and inspect the quality of care of all NHS services in England and the UK, respectively. NHS Improvement consults NHS trusts and foundation trusts on ways to meet and maintain safety, quality, and financial targets. They hold providers accountable and intervene where necessary to ensure that the NHS meets its short-term goals by providing more direct support and potentially requesting a change in a trust's management ("NHS Improvement…"). Additionally, the CQC inspects, surveils, and rates services based on safety, care, leadership, effectiveness, and responsiveness ("CQC: Who We Are"). Overall, the new NHS in England, under the Health and Social Care Act, was designed to emphasize local decision making, put GPs in control of commissioning as CCGs, encourage patient choice, and improve quality of care and patient safety (Ham et al.). These changes led to the NHS being recognized as one of the best health care systems in the world.

NHS Performance

Strengths

Despite the complaints and calls for reform, people living in England have generally enjoyed the benefits of a world-renowned health care system. A study by the Commonwealth Fund in July 2017 places the UK NHS, as a whole, as the highest-ranked health care system based on five domain areas (Table 1).[2] Impressively, the UK ranks first in two areas

[2]Data sources included Commonwealth Fund international surveys of patients and physicians together with selected measures from the Organisation for Economic Co-operation and Development (OECD), World Health Organization, and the European Observatory on Health Systems and Policies (Schneider et al., p. 3).

Table 1
Health Care System Performance Rankings

	Australia	Canada	France	Germany	Netherlands	New Zealand	Norway	Sweden	Switzerland	UK	US
Overall ranking	2	9	10	8	3	4	4	6	6	1	11
Care process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health care outcomes	1	9	5	8	6	7	3	2	4	10	11

Source: Schneider et al., p. 5.

Table 2
Eleven-Country Summary Score on Health System Performance

	Australia	Canada	France	Germany	Netherlands	New Zealand	Norway	Sweden	Switzerland	UK	US
Overall performance score	0.36	–0.26	–0.45	0.07	0.27	0.13	0.13	0.08	0.08	0.37	–0.75
Care process	0.38	0.15	–0.42	–0.12	0.29	0.36	–0.60	–0.82	–0.03	0.56	0.23
Preventive care	0.06	0.57	–0.38	–0.96	0.43	0.11	–0.34	–0.20	–0.07	0.46	0.25
Safe care	0.89	0.03	–0.38	0.08	0.18	0.29	–1.08	–0.82	–0.49	1.03	0.29
Coordinated care	–0.11	–0.23	–0.22	0.37	0.06	0.64	–0.11	–1.07	0.41	0.30	–0.04
Engagement and patient preferences	0.69	0.22	–0.71	0.04	0.49	0.40	–0.86	–1.17	0.04	0.45	0.42
Access	0.19	–0.77	–0.14	0.58	0.70	0.02	0.14	0.06	–0.11	0.39	–1.07
Affordability	0.06	–0.31	–0.59	0.67	0.28	0.15	0.46	0.69	–0.52	0.97	–1.87
Timeliness	0.32	–1.23	0.31	0.48	1.13	–0.10	–0.18	–0.56	0.31	–0.19	–0.27
Administrative efficiency	0.74	0.08	–1.41	0.08	–0.15	0.60	0.54	0.26	–0.12	0.59	–1.21
Equity	0.14	–0.39	–0.53	0.01	0.46	–0.24	0.14	0.37	0.34	0.93	–0.94
Health care outcomes	0.62	–0.35	–0.23	–0.18	0.03	–0.12	0.42	0.55	0.32	–0.63	–0.76

Source: Schneider et al., p. 18.

and third in two other areas. In the detailed scores shown in Table 2, a positive performance score indicates the country performs above the 11-country average, whereas a negative score falls below average performance. The scores are measured in standard deviations. The score for the "preventive care" area (0.46) is calculated based on individual scores from specific indicators. Examples of such indicators include "talked with provider about healthy diet, exercise, and physical activity in the past two years" and "avoidable hospital admissions for congestive heart failure" (Schneider et al., p. 18). For both these indicators, the UK received a positive performance score. The "safe care" score (1.03) is also comprised of multiple indicators, one of which includes "experienced a medical, medication, or lab mistake in the past two years." The NHS is also applauded for its equity. To calculate scores in "equity," several indicators from other domains were separated as "below-average income" and "above-average income" among respondents, and the performance score was determined from the percentage point difference between respondents from those two categories. The UK emerged with the highest domain score for equity at 0.93.

Overall, the Commonwealth Fund presents the NHS as a worthy role model when analyzed according to these measures. Secretary of State for Health Jeremy Hunt welcomed the study, saying, "These outstanding results are a testament to the dedication of the NHS staff, who despite pressure on the frontline are delivering safer, more compassionate care than ever" (Triggle). The study, along with Hunt's remarks, was only able to calm a small fraction of those worried about their beloved NHS.

Nonetheless, the NHS faces challenges in the "health care outcomes" domain (see Tables 1 and 2). Strikingly, the UK ranks second to last in this area. Within that domain, the UK scores poorly in "mortality amenable to health care." Nevertheless, because of the efforts made to strengthen its service, the UK also has the largest 10-year decline in mortality amenable to health care (37%) (Schneider et al., p. 24). Above all, this information depicts the strengths of the British health care system and also its dedication to improve.

Weaknesses

As patients' needs changed, the NHS in England developed shortcomings and inadequacies. The organization addressed these issues in the NHS 2014 report, "Five Year Forward View," which outlines the ways in which the health service must change and sets forth specific actions. In March 2017, a follow-up report, "Next Steps on the NHS Five Year Forward View," covered the headway made since the initial report and laid out practical steps for achieving better results for the remaining two years. One target for 2017/2018 under the Primary Care section reads, "*Boost GP numbers*. The Government has set an objective of an extra 5000 doctors working in general practice by 2020" ("Next Steps…"). Additionally, the specific means to reach this goal include increasing funding, encouraging practices to collaborate, and developing a new GP contract.

To assess the NHS' performance against these goals, the King's Fund released a Quarterly Monitoring Report (QMR). The report finds that despite the increased funding, meeting finance targets remained unpredictable, and the NHS in 2017 was actually performing worse than in the previous year when measured against a few critical indicators. One of the most salient challenges has been the overpopulation of accident and emergency (A&E) departments. For example, 89.7% of A&E patients were treated, admitted, or transferred within 4 hours in the last quarter of 2017. This missed the 95% standard set in the "Next Steps…" report, despite a £100 million increase in capital funding in the spring of 2017 to enable clinical streamlining in A&E departments and £1 billion to the social care system to facilitate transfer of care from hospitals. Although providers initially expected worse outcomes for the quarter, the fact that the miss was narrower was mostly due to the dedication of the NHS staff at the frontlines but also a reorganization of priority dictated in "Next Steps…". Compared to the previous year, 700,000 more people spent longer than four hours in A&E in the 2016/2017 year ("The State of Health…"). In comparison, Victoria, Australia; Ontario, Canada; and Stockholm, Sweden all have lower targets and worse

performance for their 4-hour A&E wait times—targets for those cities are set at 75%, 90%, and 71% to 79%, respectively ("International Comparisons…," p. 4).

To help providers focus more on meeting A&E targets, "Next Steps…" lowered the priority of the 18-week referral-to-treatment target, meaning this target became less important to meet than others. By August 2017, 89.4% of patients waiting to start treatment received treatment within 18 weeks, below the 92% national standard (Anandaciva et al.). The waiting list for elective treatment reached its highest level since August 2007, at 4.1 million patients (Anandaciva et al.). Although it caused an increase in waiting times, this strategy also helped release pressure from CCGs that have to purchase care from providers. To meet performance targets, these providers are now focusing more on unprofitable A&E work while neglecting the profitable elective work. Yet, in doing this, trusts risk missing financial targets and losing access to certain bonuses in pay.

Another example of the stresses the NHS is experiencing can be seen in the CQC account of safety standards. The CQC 2016 annual report, "The State of Health Care and Adult Social Care in England," shows that on re-inspection of services initially rated as good, several have received lower ratings of requires improvement or inadequate. Precisely, 23% of adult social care services, 2% of GP services, 18% of NHS acute hospitals, and 26% of all mental health services have dropped in rating ("The State of Health…"). Regarding NHS acute hospitals, this translates to 54% now rated as requires improvement or inadequate ("The State of Health…"). Despite these ratings, the public still considers their health care very highly, as is evident in the Commonwealth Fund study (see Tables 1 and 2). Combining the reports of the CQC and the Commonwealth Fund, it is clear that the British people simply have high standards for their health care system.

NHS staff across England, as opposed to the system itself, have done more than their share of the work to maintain those standards. In the QMR, Anandaciva and colleagues write, "As frontline staff try their best to improve quality of care and access for patients, it is increasingly apparent that we are setting them an unachievable task." Unfortunately, the main challenges stem from areas largely outside the control of the health providers themselves.

Main Causes of Poor Performance

Growing and Aging Population

There are several factors that contribute to rising demand and sagging performance of the NHS; one is the growing and aging population. Between 2001 and 2015, the population of England rose from 49.5 million to 55.3 million (Office for National Statistics, "Population…"). Additionally, as medical research makes larger strides, people are living longer. In those same 14 years, the number of people aged 65 and over rose from 7.7 million to 9 million (Office for National Statistics, "How Does the UK…"). People are now more likely to die from chronic diseases than infectious ones, meaning that more money is spent on the continuous and complicated care of each patient. Data show that the average 85-year-old man costs the NHS approximately seven times more money than the average man in his late 30s (Robineau).

Because of the change in demographics, the NHS is experiencing a substantial rise in demand. Between the years 2003/2004 and 2015/2016, attendances at major A&E departments increased by 18%. In addition, hospital admissions through those A&Es have increased by 65% in the same time period. Total referrals for elective care to outpatient services have seen a 62% increase between 2003/2004 and 2016/2017. Ultimately, the rise in A&E usage, elective care, mental health services, and ambulance services has led to a total increase in NHS activity. From 2.5 million patients in the second quarter of 2006/2007 to 5.3 million at the same time in 2016/2017, NHS activity increased by 109%—a 7.4% average annual increase (Maguire et al.).

Decline in Hospital Beds

As demand has been increasing, availability of hospital beds has been decreasing. In fact, over the last 30 years, the number of hospital beds in England has been reduced by over 50% ("The NHS Crisis…").

The largest percentage changes in number of beds have been in learning disability, mental health, and elder care beds, which have fallen by 96.4%, 72.1%, and 60.8%, respectively, since 1978 (Ewbank et al.). At the same time, the number of day-only beds has grown by more than 520% (Ewbank et al.). These numbers reflect the change in policies that aimed to increase support for people as outpatients rather than inpatients. Although, given that A&E departments are struggling to transfer patients from lobbies to wards because of lack of bed space, the reduction seems regrettable. To put this in a wider perspective, the UK has fewer beds per 1,000 people (2.6) than most other developed countries, according to data from the OECD. Compared to rates of beds per 1,000 people in Germany (8.1) and in Belgium (6.2), the UK's lack of beds presents a serious problem for the NHS.

Funding Restraints

The leading topic of discussion regarding the NHS is its lack of funding. The proponents of Brexit during the 2016 EU referendum used this issue to sway a multitude of voters, displaying advertisements on buses that read: "We send the EU £350 million a week—let's fund our NHS instead. Vote leave." It was later discovered that the statement was inaccurate, but the damage had already been done. The public was crying out for the funding they felt the NHS so desperately needed.

The root issue is simply a matter of supply and demand. While the cost to run the NHS rises 7% and demand by 3% to 4% on average every year, the rate of increase in NHS funding has been slowing rapidly (Teach Me). Since 2010, NHS funding has been growing an average of only 1.2% per year ("Health and Social…"). In fact, according to the OECD, the UK spends the second lowest on health care per capita compared to other G7 countries (Office for National Statistics, "How Does the UK..."). Several NHS staff continue to raise their concerns that the UK might not be spending enough on health care (Hutt).

The King's Fund QMR shows just how uncertain the financial stability of the health care system is. Their survey revealed that 43% of trust finance directors expected to overspend their budgets in 2017/2018. NHS trusts and CCGs are utilizing a variety of measures to cope, some of which include delaying payments to suppliers, extending waiting lists or reducing activity for particular elective services, and taking out loans from the Department of Health (Anandaciva et al.). The mounting financial pressures have led to an increase in loans for bills and staff salaries. The survey showed that 52% of trust directors were very concerned with their ability to pay back the loans.

Staff Retention

Limited retention of NHS staff is another major factor contributing to NHS challenges. According to the *Guardian*, the Labour party estimates the NHS in England is in need of 42,855 more nurses; 12,219 more nurse support workers; and 11,187 more doctors (Campbell, "NHS Hospitals…"). In 2016/2017, more than 33,000 nurses left the health care system, resulting in an overall shortage of 3,000 personnel and a 20% increase in nurses leaving since 2012/2013 (Siddique). The 2016 referendum might have worsened the retention issue. In 2014/2015, before Brexit, 2,416 EU nurses quit, while 5,977 joined; comparatively, 3,985 nurses quit and 2,791 joined post Brexit (Siddique). Given the dependence on foreign health care workers, Director of Policy and Strategy at NHS Providers Saffron Cordery suggested that uncertainty regarding the rights of EU workers following the Brexit vote is one of the reasons behind this trend (Gallagher).

The more widespread motive for leaving can be attributed to the rising expectations put on staff within the collective health system. As the population and life expectancy increase, more care is required for the elderly. The rising demand combined with vacant posts in hospitals also produce the "weekend effect"—statistics indicate that outcomes are worse for patients admitted on the weekends. The government began to combat these problems by working to better integrate the NHS and social care and emphasizing a seven-day work week to decrease amenable deaths over the weekend. The goal was to make care more available for the elderly and fix the disparity in health outcomes for those admitted on the weekend.

This effort ultimately increased pressures on staff (Metcalf). Historically, the Department of Health has mitigated staff shortages by increasing pay. Despite its previous success, that strategy has not been employed by the current administration, a decision that is cause for low morale and further loss of staff. All these factors cause a downward spiral: loss of staff engenders increased pressures, which in turn prompt more staff to leave and then results in even more pressures.

Recommendations

Any substantial change that does not include increased funding would be extremely difficult to implement. A survey done by the King's Fund revealed that "66% of adults are willing to pay more of their own taxes to fund the NHS, underlining growing support among the public for tax rises to increase NHS funding" (Evans and Wellings). This sentiment also comes with heavy support against privatization, revealing it to be an unrealistic solution for the near future.

Instead, a more pragmatic approach might be allocating money to open up more beds. This would help ease conditions in A&E during high demand and allow for more surgeries. Alternatively, to address the bed crisis with current funding levels, more emphasis could be placed on integration of acute hospitals and social care facilities so transfer of care can be streamlined. As opposed to putting increased priority on the A&E waiting numbers, the NHS should focus on more upstream challenges, such as reducing delayed transfers. A final suggestion to keep beds available during high demand is limiting non-essential surgeries during the winter. The NHS is always under greatest pressure during the months of December to February because of the cold weather and seasonal flu outbreak. Withholding certain elective surgeries during that time would certainly open up several bed spaces and operating rooms.

Lastly, without Brexit policies protecting EU immigrant workers, the current trend of a decreasing workforce is expected to continue. Although Hunt promised to boost the number of GPs by 5,000 in 2020, current statistics still show that numbers are declining, and the goal is unlikely to be met (Kaffash). To place a Band-Aid on this issue, the government will have to look toward overseas recruitment. Brexit negotiations that guarantee safe immigration status for NHS workers for the next 5 to 10 years may be enough to allow for an increase in local GP numbers.

Conclusion

The NHS has seen better days. Once thoroughly revered, it has now come under criticism, internally and externally. Under the current administration, funding has decreased dramatically, and the consequences are clear. The accolades awarded the NHS in the Commonwealth Fund study are an image of a strong but deteriorating system—as can be seen in the missed targets—yet a stellar care process. The UK service was ranked first twice and third twice in four of the five indicators used in the Commonwealth Fund study, an achievement welcomed cheerfully by certain politicians but met with suspicion by others. Hesitation stems from the fact that the British people themselves have experienced a decline in their beloved system firsthand. A&E departments are increasingly overcrowded, waiting lists are growing, and hospitals are dropping in quality rating. Most of these challenges can be attributed to the growing and aging population, loss of hospital beds, fleeing staff, and funding restraints. Despite the challenges, the data suggest the NHS has proved resilient. Due to the already fractured state of the system, substantial improvement requires a substantial increase in funding to at least repair the damage. Hope for further change lies in the hands of the incoming staff the government has promised and a reallocation of existing resources to solve the bed crisis. Although no health care system is perfect, the NHS has the potential to regain its status as a model for other nations.

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