CHAPTER 2

SCOTLAND AND WALES

David Hughes

Introduction: Devolved governments and divergent health policies

As with other country case studies in this volume, change in the healthcare systems of England and Wales has been shaped by professionally-dominated divisions of labour of the kind described by neo-Weberian theory (Saks, 2010), and affected by pre-existing institutional structures, norms, and cultures (see: Hughes and Vincent-Jones, 2008). This is a story about how devolved governments that opposed market reforms introduced in England created integrated systems closer to the 1948 National Health Service (NHS) vision, and developed distinctive health policies that meshed with the views of their professional elites, their service histories and political cultures, even while maintaining many common features shared with their larger English NHS neighbour.

Scotland and Wales are two of the four home countries making up the United Kingdom (UK), the nation state that also contains England and Northern Ireland. The UK's Westminster Parliament determines policy on matters such as the constitution, the civil service, defence, and international relations. Under the provisions of the Scotland Act 1998 (amended by the Scotland Acts of 2012 and 2016) and the Government of Wales Act 1998 (amended by the Government of Wales Act 2006 and the Wales Acts of 2014 and 2017) assemblies were created and granted certain legislative powers. Thus the Scottish Parliament and the Welsh Senedd are able to use devolved powers to legislate in areas such as local government, agriculture and fisheries, education, and health. This differs from a federal system in that the grant of powers is made, and could be rescinded, by the Westminster Parliament, thus preserving the UK's *de jure* status as a unitary state. Health became a devolved matter on 1 July 1999. Since then each country has developed its NHS system in a distinctive way (Greer, 2004; Hughes and Vincent-Jones, 2008).

In retrospect, the Labour government devolution reforms, which at the time attracted only limited attention in health policy circles, were to have a more profound and lasting effect on the UK's healthcare system than other health reforms of that period. Following Labour's victory in the 1997 UK general election, the Blair Government initially appeared set to end the split between NHS purchasers and providers and replace the NHS internal market with an integrated system, but it quickly returned to policies favouring markets and competition. From 2003 It introduced a package of reforms that created a 'provider market' based on autonomous Foundation Trust hospitals, a role for independent-sector treatment centres, increased patient choice of provider, standard national tariffs for NHS treatments, and system regulation via arms-length agencies in the form of the Care Quality Commission and Monitor. Under the internal market system, Scotland and Wales were already leaning towards greater system integration and cooperation rather than competition, and had moved to 'soften' the market by encouraging 'partnership' working between NHS purchasers and providers. Now dissident Labour-led administrations in the Scottish and Welsh assemblies decided to break from these Westminster 'New Labour' policies. In 2004 Scotland created unified regional health boards, thus ending its purchaser/provider split. Wales continued for a few years with a soft version of the internal market in which Local Health Boards purchased services from NHS trusts, before abolishing its internal market in 2009 in favour of unified health boards. Thus the early post-devolution period heralded a striking divergence in policy as Scotland and Wales explored alternatives to the English market approach.

A shared history?

The NHS began operation across the whole of the UK on 5 July 1948, based on common principles and entitlements. The aim was to provide universal and comprehensive health services, according to need rather than ability to pay to all residents. Although the title 'National Health Service' implies a single UK-wide health service, separate legislation was used to create one NHS for England and Wales, accountable to the Secretary of State for Health, and a separate NHS for Scotland, accountable to the Secretary of State for Scotland. Similar health services in Northern Ireland were created through the Health Services Act (Northern Ireland) 1948.

During the early history of the NHS, the health systems of England and Wales were managed by the central government's main health department (initially the Ministry of Health and later the Department of Health and Social Security, the Department of Health and currently the Department of Health and Social Care (DHSC)), while Scotland and Northern Ireland were managed by the Scottish Office and Northern Ireland Office respectively. In 1969, new legislation separated the Welsh NHS from the English NHS, and put it under the control of a separate UK government department, the Welsh Office, rather than the Department of Health.

Scotland

Shortly after devolution in 1999 the Scottish Government, then a Labour-led coalition, began discussions on dismantling the internal market, dissolving trusts, promoting integration of care, strengthening primary care, and improving public health. The NHS Reform (Scotland) Act 2004 abolished trusts and transferred their functions to 15 integrated regional Health Boards (later reduced to 14) (Robson, 2011). The Health Boards have been described as 'all-purpose organisations' that plan, commission and deliver a wide range of hospital and community health services, including managing contracts with general practitioners (GPs) and dentists who operate as independent contractors. A unique feature of the reform was that the Health Boards were given powers to create Community Health Partnerships (CHPs), networks in which frontline NHS staff worked closely with local authority and voluntary agency staff to improve health services in a geographical area (Forbes and Evans, 2008).

A further significant change occurred in 2007 when a minority Scottish National Party (SNP) government came to power. Its big idea was a 'mutual NHS' as outlined in the policy document *Better Health, Better Care*. The new policy emphasised cooperation and collaboration rather than market competition, and outlined a vision of greater public involvement, improved quality driven by performance targets, and strengthened partnership working. With the election of a majority SNP government in 2011 policies based on mutuality developed further. The report of the Christie Commission on the Future Delivery of Public Services published shortly after the election suggested a framework for further reform. The perceived need for improved integration of NHS and local authority services put a question mark against the CHPs, whose track record in achieving health improvement had been questioned in a 2011 Audit Scotland Report. The 2014 Public Bodies (Joint Working) (Scotland) Act replaced CHPs with Health and Social Care Partnerships, spanning the two sectors, which became operational from 2016 (Pearson and Watkins, 2018; Taylor, 2015).

In an analysis of the language of policy documents from the four countries Prior, Hughes and Peckham (2012) point to a rhetorical emphasis in the Scottish documents on the nation and the 'people of Scotland' that gives them a more overtly nationalistic tone than the documents of the other countries. A narrative is constructed in which the Scottish population is ageing faster and dying quicker than 'any other industrial nation', that the 'Scottish people' must improve their healthcare system so that it compares with 'other European countries', that a change of the culture of both professionals and the public is needed, and that this should take a distinctively Scottish form, involving values of mutuality, co-ownership, partnership, and involvement, as well as a collective approach. In this narrative the Scottish people and the staff of the NHS are seen as partners, or co-owners of an NHS that relies on cooperation and collaboration rather than internal competition (Prior, Hughes and Peckham, 2012).

At the time of writing the Scottish Government Directorate for Health and Social Care oversees 14 territorial Health Boards, connected to 31 integration partnerships that span the Health Boards and Councils. The Directorate also manages a number of special health authorities with discrete roles, such as Public Health Scotland, and central support departments within NHS National Services Scotland.

Wales

After devolution the direction of Welsh policy initially involved a softening, rather than rejection of the NHS internal market, but in 2007 a Labour/Plaid Cymru coalition government published a *One Wales Delivery Plan* signalling the intention to end the purchaser/provider split and phase out use of the private sector for NHS work in Wales. Subsequently seven unified health authorities were created to replace the then existing 22 Local Health Boards and 7 NHS Trusts (Local Health Boards (Directed Functions) (Wales) Regulations 2009, SI 2009/1511). The Health Boards are responsible for a wide range of health services, including primary and specialised care for their populations, and share responsibility for public health services with the national Public Health Wales and the local authorities. Currently the National Delivery Group within the Department of Health and Social Services oversees the seven Health Boards and three NHS Trusts, Public Health Wales, the Welsh Ambulance Service, and a specialist cancer and blood services trust.

Since the 2009 reorganisation Welsh health policy has focused on such matters as improving population health, increased emphasis on prevention as opposed to curative services, improving joint working between health and social care, removing charges that might affect access (drug prescription charges and hospital parking charges), and reorganising structures to reduce waste. Riley (2016) identifies reduction of health inequalities as a key policy aim at this time. There was an attempt to coordinate policies targeting poverty-reduction, community regeneration, early childhood support and integrated health services. The *1000 Lives* and *1000 Lives Plus* were two high-profile programmes that sought to save lives and reduce preventable morbidity.

The Welsh Government's big idea for improving services in a period of constrained budgets is 'prudent healthcare'. This concept was developed by the Bevan Commission (2013:3), an expert group convened to advise the Health Minister, and was defined as: "healthcare which is conceived, managed and delivered in a cautious and wise way characterised by forethought, vigilance and careful budgeting which achieves tangible benefits and quality outcomes for patients". Prudent healthcare is healthcare that is parsimonious but efficient; it seeks to get more for less by minimising waste and maximising clinical effectiveness. The initiative re-assembles familiar building blocks – co-production by professionals and patients, involving people in treatment and policy decisions, treating according to clinical need rather than targets, not over-treating, accelerating innovation, increased focus on patient safety and evidence-based treatments. A recent study identifies various barriers to the implementation of co-production, including poor health literacy and understanding of the concept, poor communication between professionals and service users, and service capacity and time constraints (Holland-Hart et al., 2019). Given the unprecedented disruption of services caused by the Covid-19 pandemic, it will be many years before the effectiveness of the initiative can be evaluated.

Prior, Hughes and Peckham (2012) observe that Welsh policy documents of the early 2000s, like those of Scotland, made frequent references to national identity, but in Wales's case the policy story constructed was that of a 'small nation' that needed a fairer share of UK resources. In this policy narrative, years of underfunding needed to be confronted, and the healthcare system 'renewed' and 'repaired', the services inherited by the Assembly was overburdened and needed fundamental change, there was inadequate system capacity, organisational reform was 'vital' and would require joint working between NHS professionals, between health and social services, and between the NHS and the people of Wales. These objectives would only be achieved by "adopting Welsh solutions to Welsh challenges" (Prior, Hughes and Peckham, 2012:10-11).

Public health

Since devolution Scotland and Wales, like England, have created national agencies to lead on public health, working in cooperation with local NHS bodies and local government public health divisions. Both countries have seen periodic organisational changes since 2000. Scotland initially divided public health functions, such as health improvement and protection, between separate national agencies, but later shifted back to a single lead body, Public Health Scotland. Wales made periodic changes to the internal directorate structure of a single national public health organisation. Organisations in both countries have similar remits to improve and protect population health (including through health promotion programmes), to oversee disease prevention, surveillance and control of outbreaks and incidents, to reduce health inequalities, and to support other agencies involved in public health work.

Public Health Scotland was established as a national health board in April 2020 in order to respond more effectively to the Covid-19 pandemic, and took over the functions previously performed by Health Protection Scotland and the Information Services Division (both divisions of NHS National Services Scotland), and NHS Health Scotland (a body with a remit to reduce health inequalities). Public Health Wales is an older body, created as an NHS Trust in October 2009, and carries out similar functions to those that had been previously spilt between the Scottish organisations via its various internal divisions. The 14 Scottish regional Health Boards and 7 Welsh Health Boards each have a Director of Public Health who is supported by the national bodies. In the past decade, as in England, local government authorities in both countries have also been given greater responsibilities for public health, and the work of public health teams extends to programmes addressing health inequalities and health improvement, as well more traditional areas such as environmental health, sanitation and food safety (Campbell, 2018). Public Health Wales and Public Health Scotland thus each sit at the centre of a network that includes their respective devolved governments, health boards, local authorities and other agencies. In Scotland the role of the local authorities has been given more prominence than in Wales by making the Public Health Scotland formally accountable to both the Scottish Government and the Convention of Scottish Local Authorities.

A further element in this complicated web of organisations was the replacement of Public Health England in April 2021 with the UK Health Security Agency, an executive agency of the DHSC, again as a response to the Covid-19 pandemic. The new body has certain UK-wide responsibilities, such as providing national public health science and response capabilities – not least cutting edge analytics and genomic surveillance (Department of Health and Social Care, 2021). Exactly how these duties intersect with the work of the Scottish and Welsh agencies, given that health is a devolved matter, remains subject to negotiation at the time of writing. Commenting in June 2021 on how the network of governments and other involved agencies operates, a senior Public Health Wales source approached as background for this chapter said the "governance map … is complicated, emerging and subject to agreements of Welsh Ministers – so it is not easy to capture all at present!"

The impact of devolved policies on finance and performance

The devolved administrations receive an annual block grant to fund public services from the UK government. Per capita public expenditure is higher in the devolved countries than in England because of the Barnet Formula that determines allocations for public expenditure from the UK Treasury. In 2019-20 Scotland received £11,604 per head, and Wales £10, 929, compared with £9,604 for England (HM Treasury, 2020). In 2018-19, the last 'normal' year before the pandemic, NHS spend per head was £2,396 for Scotland, compared with £2,402 for Wales and £2,269 for England, reflecting the budget allocation choices of the devolved administrations (Nicholson and Shuttleworth, 2020). The higher expenditure in Scotland and Wales partly reflects higher costs associated with geography and demography, but must be borne in mind when assessing performance.

While comparative studies of policies concerning patient choice, patient and public involvement, and health inequalities have confirmed that there are real differences in the approaches taken by the UK countries, findings on system outcomes as set out in Box 2.1 below do not show that any system has a clear performance advantage. Comparisons are difficult because of different methodologies for

collecting official data across the four countries. The preface to a major UK-wide comparative study by the Nuffield Trust from 2014 states that the "different policies adopted by each country appear to have made little difference to long-term national trends on most of the indicators that the authors were able to compare. Individual countries can point to marginal differences in performance in one or more areas" (Bevan et al., 2014:8). The detailed findings suggested that at that time England and Scotland were doing slightly better with hospital waiting times than Wales and Northern Ireland, but does not establish whether English-style market levers were necessarily better than Scottish performance management.

Box 2.1: Performance against key NHS standards at December 2019

Scotland

- 88% of attendances at A&E services were admitted, transferred or discharged within 4 hours (missed 95% standard)
- 78.9% treated within 18 weeks RTT (referral to treatment) standard (missed 90% standard)
- 83.3% of patients started cancer treatment within the 62 days of referral (Missed 95% standard).

Wales

- 74.4% of attendances at A&E services were admitted, transferred or discharged within 4 hours (missed 95% standard)
- 83.5% treated within 26 weeks RTT standard (missed 95% standard)
- 80.6% started cancer treatment within 62 days of suspected diagnosis (missed 95% standard).

England

- 79.8% of attendances at A&E services were admitted, transferred or discharged within 4 hours (missed 90% standard).
- 83.7% on incomplete RTT paths waited 18 weeks or less (missed 92% standard).
- 78% of patients started cancer treatment within the 62 day of referral (missed 85% standard).

Source: Scottish Government, 2022; Statistics Wales, 2020; NHS England, 2020.

Interestingly Scotland combined a policy emphasis on 'mutuality' with willingness to use hierarchical command and control. Guthrie and colleagues (2010) argue that there was a blend of mutuality in the form of 'control through group processes' and government 'oversight' that included performance management. From 2006 Scottish Health Boards were required to meet new HEAT (health, efficiency, access and treatment) targets, which were to become a distinctive feature of the Scottish system and more rigorous than the equivalent systems in Wales and Northern Ireland (Steel and Cylus, 2012).

Following the 2008 financial crisis the performance of all four UK systems was affected by UK central government austerity policies. Audit Scotland reported a real terms reduction in NHS spending of about 0.7% between 2008-09 and 2014-15 (Auditor General Scotland, 2015). This was partly the result of the failure of the block grant from the UK central government to keep pace with inflation, and also because Scotland opted to share available resources across social services and other departments rather than protect NHS budgets, as Wales had done. Reduced funding contributed to problems of rising waiting times and uneven staff recruitment. In the early years after devolution it was suggested that the HEAT target system allowed Scotland to cope better with austerity than the other devolved administrations (see Steel and Cylus, 2012), but waiting times have continued to be a

problem, and in 2015-16 HEAT targets were replaced by Local Delivery Plan Standards, which focused more on waiting times targets.

After this relatively strong performance in earlier years, the Scottish government has faced recent criticism for failing to hit national NHS targets. Only one of the eight key national waiting times standards was achieved in 2017-18 and two in 2018/19. In the latter year performance declined for six out of the eight standards, with the exceptions being outpatient waits of under 12 weeks following first referral and the 31-day cancer waiting times target (Auditor General Scotland, 2019). Any precise assessment of the relative performance of Scotland and Wales on such measures is problematic because each country uses slightly different standards, although Box 2.1 shows that for three high-profile targets there is little to choose between the countries, and little difference from England.

NHS Wales was widely criticised in the early 2000s for its long waiting times and its standard for referral to treatment (RTT) being set at 26 weeks compared with 18 weeks in the other home countries. As time has passed the gap has become smaller, with performance in Scotland and England falling back. A 2015 Auditor General Wales (2015:11) report concludes that: "Overall, the NHS has improved against some public health measures and against some of its key performance measures on quality. But … performance against measures of waiting times – for elective care, emergency care and cancer care – have deteriorated". Problems in managing waiting times – especially in orthopaedics and ophthalmology – meant that several health boards increased the value of activity undertaken by private providers, causing politicians to backtrack from earlier promises to end use of the private sector for NHS work.

The Covid-19 pandemic

In the early days of the pandemic all four home countries benefited from advice from the existing UK scientific advisory structures (House of Commons, 2020). The Scientific Group for Emergencies (SAGE) reported to the UK Cabinet Office Briefing Room meetings and the Civil Contingencies Secretariat, a body within the Cabinet. SAGE brought together advice from specialist subgroups that included the Scientific Pandemic Influenza Group on Modelling, the Scientific Pandemic Influenza Group on Behavioural Science, and the New and Emerging Respiratory Virus Threats Advisory Group. The experience in setting up field hospitals, first created in London, was shared across the UK. All constituent countries began a compulsory lockdown on 23 March 2020, under powers contained in the Coronavirus Act 2020. Throughout the pandemic, personal protective equipment, diagnostics, ventilators, and vaccines were procured centrally on an all-UK basis. It was only in May 2020 when the UK Government announced a phased relaxation of restrictions, guided by a newly established Joint Biosecurity Centre, that the devolved administrations complained about a lack of consultation and began to diverge from a shared UK-wide approach (Anderson et al., 2021). Scotland established the Scottish Government Covid-19 Advisory Group, while the Welsh Government created a 'technical advisory cell', both to adapt SAGE guidance for their territorial contexts.

The UK's speedy roll out of vaccinations compared with European neighbours helped shield the government from criticism for high death rates in 2020, but even here Wales and Scotland followed different approaches. In June 2021 Audit Wales reported that Covid-19 vaccination rates in Wales were the highest of the four UK countries, and among the highest in the world (Auditor General Wales, 2021). Wales adopted UK prioritisation guidance from the Joint Committee on Vaccination and Immunisation, and messaging from the UK and Welsh governments has generally been consistent. After criticism for a slow start in February 2021 the pace of vaccination rollout quickly improved. Initially immunisers were all registered NHS professionals, but this was extended to include general practice staff, and then trained non-registered immunisers, including military personnel. An assessment by the military of sites and operating procedures for mass vaccination centres is said to have aided the pace of rollout. It has been suggested that a key factor in Wales' high vaccination rate was that the Welsh Government was prepared to use a higher proportion of available stocks soon after receipt, taking the gamble that further supplies would arrive in time for second

vaccinations (Ferris, 2021). Wales also opted to move through the age cohorts more quickly than other parts of the UK, while tolerating lower uptake in top priority groups.

In mid-2021 Scotland's vaccination rate was lower than that of both Wales and England. There was a slower progression through the cohorts, but greater uptake within high-risk groups than in Wales. Critics suggest that Scotland suffered because it was slow in opening mass vaccination centres, while vaccine supplies to GPs were affected by the complexity of Scottish supply chains. They contend that the Scottish Government was slow to cooperate from the UK central government, with Scotland only negotiating the deployment of military personnel in mass vaccination centres many weeks after Wales (Rossiter, 2021). There have also been suggestions that Scotland's concern with 'mutuality' and equitable shares to health boards according to population share and geography slowed distribution (Maishman, 2021). Generally, the rules and timetable of public health measures introduced in Scotland were further from the English approach than was the case for Wales.

However, as the pandemic progressed it was not clear that Wales' impressive vaccine roll-out had translated into a clear advantage in terms of lower infection and death rates. In the period before May 25th 2022 when Public Health Wales ceased to update data for its 'Covid-19 dashboard', the rate of estimated daily infections in Scotland was mostly lower than that in Wales, although the relative positions of the two countries fluctuated week by week. For example, in the week ending May 13th 1 in 45 people in Scotland were estimated to be infected with Covid-19 compared with 1 in 40 in Wales. Yet in the week ending 21st May the pattern had reversed so that 1 in 40 were estimated to be positive in Scotland, while the Welsh figure was 1 in 55 (ONS, 2022). By May 25th 2022 deaths in which Covid-19 was recorded as a factor on the death certificate stood at 12344 in Scotland and 10308 in Wales (Public Health Wales, 2022; Public Health Scotland, 2022), which indicates a lower mortality rate in Scotland, given a Scottish population of about 5.46 million compared with under 3.3 million living in Wales. Of course, a range of geographic, demographic and social factors, apart from differences in public policy, are likely to have affected these outcomes.

Sustainability

NHS-type systems throughout Europe are facing a squeeze arising from a combination of constrained budgets and increased demand that raises questions about sustainability. While the NHS across the United Kingdom saw a modest rise in budgets in the years after the millennium, the global financial crisis of 2008 heralded a period of austerity in which real terms government funding barely rose. Against a background of tightening budgets, Scotland and Wales must both cope with increasing levels of service utilisation arising from ageing populations and high rates of chronic illness. Compared with England, the sparsely-populated geography of the two Celtic countries also means they must support the higher costs of providing services in rural and remote areas.

Across the UK home countries, Wales has the oldest population, with Scotland in second place. Thus 21% of the population in Wales is aged 65 and over, compared with 19.1% in Scotland, and 18.4% in the more populous England. Against this, however, the proportion of over 65s in Scotland is rising faster than in England and significantly faster than in Wales (Office of National Statistics, 2020). A recent study by Public Health England (2020) found that the burden of disease, as measured by the Global Burden of Disease methodology, is higher in both Scotland and Wales than in England. A Welsh study published by the Health Foundation (Watt and Roberts, 2016) determined that about 58% of total inpatient spend goes on treating patients with at least one of 12 chronic conditions, and that this rises to 72% of expenditure for patients aged 50 and over. The highest costs come from admissions of patients with coronary heart disease or heart failure, chronic obstructive pulmonary disease, asthma, and cancer. A Scottish study by Barnett and colleagues (2012) found a similar pattern of chronic disease, and noted that over 23% of persons registered with 314 general medical practices suffered from multimorbidity (two or more chronic conditions). This was a particular problem for older people, but affected those suffering socio-economic deprivation 10-15 years earlier than the most affluent.

In Wales around 30% of the population lives in rural areas (Gartner, Gibbon and Riley, 2007), while in Scotland the figure is about 20% (MacVicar and Nicoll, 2013). Providing equitable healthcare provision in sparsely populated areas presents logistical and economic challenges. While there is a perception that health is generally better in rural as opposed to urban locations, the picture appears uneven so that there are pockets of deprivation. Rural populations are generally older than urban populations, compounded by outward migration of young people and inward migration of older people, and more likely to face challenges in accessing services.

While ageing populations and the rising incidence of long-term illness and multimorbidity are important drivers for rising demand for healthcare services, there may be other factors that contribute to increased utilisation. Wider socioeconomic factors such as housing, employment, and changes to benefits and universal credit, have also been noted as contributing factors to demand (Watt and Roberts, 2016).

In both Scotland and Wales there are questions about how well NHS organisations with severely constrained budgets can cope with rising demand. Problems are similar to those of NHS England and include financial distress because of current or cumulative deficits, lower than planned income, overspending on commissioning of specialised services, year-on-year transfers of capital allocations to revenue, rising provider costs, and problems in staff recruitment and retention (House of Commons, 2019). Although deficits in Wales have been smaller than in England, four of the seven health boards had significant historic debt in July 2020 when the health minister announced that the Welsh Government would write off £480m owed by the Boards for strategic cash support (Donovan, 2020). At the time of writing, three Welsh Health Boards were operating with significant year-on-year deficits. A number of Scotland's 14 Health Boards had been reliant on similar Government 'brokerage' loans to cope with ongoing financial problems, and these debts were written off in 2019 as part of a 'new deal' associated with the introduction of three-year, rolling budgetary balance requirement (Auditor General Scotland, 2019). In 2021 four Health Boards were reported to be experiencing ongoing financial distress, and required to repay loans accrued since 2019 once the Covid-19 crisis ended (Auditor General Scotland, 2021).

Questions about the financial sustainability of the NHS are as old as the service itself, and the positive assessment contained in the Guillebaud Report (House of Commons, 1956) was an important watershed in overcoming early political opposition to public healthcare. A recent House of Lords (2017) report on the future of the NHS across the UK stated: "Our conclusion could not be clearer. Is the NHS and adult social care system sustainable? Yes, it is. Is it sustainable as it is today? No, it is not. Things need to change." Recent reports from Wales and Scotland echo the view that the NHS can survive, but will need radical transformation. Since the Wanless Review (Welsh Assembly Government, 2003) the general strategy in Wales has been to focus more on prevention and early intervention, and reconfigure services so as to develop primary and community care and relieve pressure on the acute sector. Watt and Roberts (2016) map out a 'path to sustainability' for Wales that depends on additional funding in line with General Domestic Product (GDP) increases and a continuation of the present trend of efficiency savings. They see Wales' prudent healthcare principles of improving care and doing 'only what is needed' as key mechanisms for increasing value for money. The Welsh NHS Confederation (2017) suggests that this approach is widely supported by NHS managers. It reports that NHS bodies are "seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing Prudent Healthcare" (Welsh NHS Confederation, 2017:1). Funding and demand pressures that threaten sustainability have also been a recurrent theme of recent Scottish Auditor General reports, and again the message has been that the service can survive by adapting to changing conditions.

A recent systematic assessment of the future of the NHS by the LSE-Lancet Commission concludes that the service is sustainable to 2030 and beyond providing that policy makers commit to sufficient investment and improvements in resource management, workforce recruitment and retention, disease prevention, health protection, clinical diagnostics, organisational learning and

integration of health and social care services (Anderson et al., 2021). The Commission notes that market-based reforms have not shown evidence of benefit to date, and advocates the continuation of a 'publicly funded NHS for all'. It advocates improved coordination in managing the healthcare systems of the four UK countries, a move towards greater data standardisation to facilitate comparative research, and more emphasis on mutual learning.

Political commitment to the NHS remains strong in both Wales and Scotland. Both have their founding stories of early mutual or public healthcare initiatives that foreshadowed a national health service. Welsh politicians can point the Tredegar Workmen's Medical Aid Society and the inspiration it provided to Aneurin Bevan, the Minister of Health who oversaw the foundation of the NHS in 1948 (Launer, 2019). Scots recall the state-funded Highlands and Islands Medical Service that provided low-cost healthcare to those living in much of remote and rural Scotland between 1913 and 1948 (McCrae, 2003). The majority parties in both countries, Welsh Labour and the Scottish Nationalist Party, have alleged that the UK Conservative government is intent on creeping privatisation of an NHS that they promise to protect. Recent opinion polls suggest that the NHS enjoys continuing strong support from the general publics in both countries.

Are the systems still faithful to the founding principles?

The establishment of the NHS in 1948 was viewed by its architects as an emphatic rejection of the healthcare market; health was to be a public good that would be both publicly financed and publicly delivered to the UK population. There would be a long period of post-war consensus in which the public NHS enjoyed wide support, including from right-wing Conservative Ministers such as Enoch Powell who delivered a huge state-funded capital programme in the 1962 Hospital Plan. It was only in the 1980s that the political tide turned to favour markets and private sector methods with the Griffiths general management reforms, the growth of contracting out of hospital support services, greater use of private hospitals to reduce NHS waiting lists, and the various iterations of the NHS internal market.

Market-oriented reforms, and the opposition they provoked in Scotland and Wales have created schisms in the NHS, and substantially re-shaped the UK healthcare landscape. However, a vision of a market-style English NHS existing in uneasy tension with alternative Celtic versions that remain truer to the original Beveridge vision oversimplifies what is a complicated and changing picture. Three elements that must be taken into account are first, recent changes in NHS England that move it back in the direction of a planned, mainly publicly-delivered service, second, the leakage of certain neo-liberal instruments in the Scottish and Welsh systems, and third, the many commonalities that these three NHS systems still share.

Since the enactment of the Health and Social Care Act 2012 the English NHS has witnessed a remarkable policy U-turn, so that legislation that appeared to open the way for privatisation and competition has been largely subverted by the creation of new entities that have no legal foundation in the Act. In outline, a system that had seemed to be about competition in a provider market unexpectedly turned back to cooperation and 'place-based planning'. As a self-protective reaction to austerity, front-line NHS bodies – the Clinical Commissioning Groups, NHS providers and NHS England's area teams – acted in concert to create new, non-legally sanctioned organisational structures to provide integrated services in local areas and maximise what could be achieved with limited budgets. The story of sustainability and transformation plans, accountable care organisations, integrated care systems, and area-based local health economies or 'footprints' lies outside the scope of this chapter (see Moran et al., 2021; Paton, 2021), but in outline mean that changes introduced on the ground in recent years have narrowed the gap between England and the other UK countries.

Moving to the second point, the greater scale and central resources of NHS England result in many policy spill-overs and leakages from that system into the Scottish and Welsh NHS systems, especially the latter. For example, NHS Wales has a service level agreement with the National Institute for Health and Care Excellence (NICE) to utilise its technology appraisals, clinical guidelines and interventional procedure guidance, as well as public health and social care guidance and the NICE

Quality Standards and Clinical Pathways. The Welsh 1000 Lives Improvement Patient Flow Programme was inspired by the Health Foundation's Flow Cost Quality programme that had been successfully rolled out in several English hospitals, and the Principality's 'expert patient programme' was heavily influenced by development work undertaken by the equivalent English programme. Both Wales and Scotland make tertiary care referrals to English providers, and must pay for this activity using standard prices based on English 'Payment by Results' tariffs, albeit with smaller patient flows coming from Scotland that are largely restricted to 'highly specialised services'. More generally, there are mutual influences and a degree of convergence in several areas of health policy (Wallace, 2019).

Like England, Scotland and Wales continue to make use of independent providers to treat NHS patients, and indeed spending on this has risen in recent years (Auditor General Scotland, 2015; Smith, 2018). SNP campaigning in the run-up to the 2015 Scotland independence referendum had claimed that the ongoing English NHS reforms were a prelude to privatisation, yet spending on private treatments by the NHS in Scotland rose by about 18% in real terms in the five years to 2015 (Auditor General Scotland, 2015). This was mainly to meet waiting time targets by increasing short-term capacity, but also to provide some specialist services not available in public hospitals. Stubbornly rising waiting lists led the Welsh Government to shelve the promise in the *One Wales* document to end use of private sector treatments by 2012. Welsh Health Board expenditure on private providers rose from £13.8 million in 2010-11 to £61 million in 2019-20 (Auditor General Wales, 2020).

Finding funds for major capital projects was difficult in a period of austerity, when the value of block grants under the Barnet formula has fallen in real terms. As a means of accessing funds both devolved countries have used private finance initiative (PFI) type contracts to build and run health and social care facilities, with numbers of projects lower than in England but not wildly out of line with relative populations. Scotland has used private capital more than Wales, and the high cost of PFI and its successor the 'non-profit distribution' model was heavily criticized in a report from Audit Scotland and the Accounts Commission in January 2020. In 2019 the Scottish government announced it would be adopting Mutual Investment Model used in Wales, an alternative 'off book' system of harnessing private capital to build public-sector infrastructure that remains controversial.

The third point to consider is that Scottish and Welsh systems still bear a strong family resemblance to the English NHS, despite the emerging differences. The degree of divergence is limited by shared organisational histories and continued commitment to the founding principles of the 1948 service. All the UK NHS systems continue to be funded from general taxation, with health spending being the largest item in the budgets of the devolved administrations. Although there are differences in eligibility for free drug prescriptions and eye tests and NHS dentistry charges, medical treatments remain free at the point of need. All the systems are subject to a high degree of political direction from the national or devolved governments, with politicians generally held accountable for any shortcomings in service provision and delivery. The terms and conditions of employment and pay of staff in the various health professions are essentially the same. In all four countries almost all GPs, NHS dentists and NHS pharmacists are contractors rather than direct employees. Moreover, the training pathways for the workforce are similar across the UK and subject to the same framework of regulation; professionals trained in Scottish medical schools or university nursing departments can work in England and Wales and vice versa. Devolution has transformed NHS governance arrangements, but it could be argued that the approaches and instruments deployed across all the UK countries was anyway moving on from the old-style central control structures of the 1948 model.

Even when market policies were in vogue, the governance of public services in the UK could be best characterised as 'centralised decentralisation', involving combinations of continued hierarchical control as well as delegation and devolution (Vincent-Jones, 2006). In England, with the purchaser/provider split still in place, decentralisation has taken the form of the delegation of service contracting and other responsibilities to local purchasers and agencies, while in Wales and Scotland the emphasis has been more on initiatives intended to increase engagement with local communities.

The devolved administrations have given a fresh twist to command and control by portraying this as control by government departments located close to the populations they serve. Both Wales and Scotland position themselves as small countries within a system of multi-level governance, albeit in different ways. At the time of the original devolution settlements, Labour Party-led coalitions in both countries worked within the framework of reserved and devolved powers granted by the Westminster Parliament, and so implicitly accepted a place in a truly United Kingdom. NHS policies could be tailored to the needs of Welsh and Scottish populations, but still looked towards important elements of a shared NHS. Wales' vision of small country governance involves centrally-organised health and social services that achieve greater citizen responsiveness by improved centre-periphery 'connections' and better coordination at both departmental and local levels (see Hughes, Mullen and Vincent-Jones, 2009). Interestingly Wales, like England, has used the idea of networks as an alternative to hierarchical management structures in its policy document, using the words "a new Welsh public service based on flexible networks of diverse pathways involving a range of organisations, all working to a common citizen-centred model" (Welsh Assembly Government, 2006: para 2.24). Scottish policy documents also emphasize the importance of citizen engagement, partnerships and integrated services. But in a sparsely populated country of highlands and islands they put less emphasis on close centre-periphery connections, and more on the viability of the nation. Thus the SNP, the ruling Party in the Scottish Parliament since 2011, has long argued that sustainable independence for Scotland depends on membership of a larger economic entity in the form of the European Union (EU) (Ichijo, 2004).

Conclusion: An uncertain future?

At present Scotland and Wales have each adopted an NHS system tailored to their own political preferences, but it is uncertain whether these arrangements will endure in the long term because of the divergent dynamics of devolved Governments and nationalist movements. In the 2021 Senedd elections the Welsh Labour Party was returned to government with an increased majority over its nationalist rival, Plaid Cymru, and remained strongly committed to continued union with the other UK countries, albeit within an enhanced devolution settlement. By contrast the corresponding elections for the Scottish Parliament left the Scottish Nationalist Party in a dominant position, heading a coalition with the Green Party strongly committed to an independence referendum and an application to re-join the European Union. There would be many obstacles to be overcome and many years would pass before that aspiration could be achieved, but if it came to pass Scotland would join the minority of European nations that retain the NHS model, rather than the social health insurance (SHI) model favoured by the EU's most powerful member states.

The future of the Scottish healthcare system might then be shaped by the same forces affecting other European NHS-type healthcare systems considered in this volume. The EU regards healthcare as a non-economic 'service of general interest' (SGI), a service that public authorities must provide either through market or non-market mechanisms in order to satisfy their public service obligations. Article 14 of the Treaty on the Functioning of the EU allows considerable flexibility in the mode of provision when it states that SGIs must "operate on the basis of principles and conditions, particularly economic and financial conditions, which enable them to fulfil their missions". In the healthcare field this allows national governments freedom to determine the organisation and funding of services as long as they conform with general EU principles, but it is not certain whether this degree of policy subsidiarity will continue into the future, given the trend towards convergence in many areas of economic and social policy. If a more uniform European approach to healthcare begins to emerge, there seems a high probability that this would involve convergence towards SHI rather than the NHS model. Exactly what would emerge remains uncertain because of a blurring of the boundaries that separated the classic Beveridge and Bismarck systems. In some countries, such as France, contributions-based funding has been supplemented by funding through taxation. However, any hybrid system would probably involve the widespread use of private-sector providers and co-payments characteristic of current SHI systems. Even if NHS-type systems survive, there are questions about their resilience in the face of the current trend of European economic and financial policies, which for Eurozone countries include the rules of the Growth and Stability Pact and 'Six

Pack', and appear to have contributed to the austerity that has impacted negatively on the healthcare systems of the Mediterranean sub-region, not least on that of Greece. The idea that Scottish independence is compatible with the conferral of powers that EU membership entails remains controversial, and critics have questioned whether an escape to Europe would merely replace UK neo-liberalism with the neo-liberalism of the EU's economic policy framework (Paterson, 2015).

It seems clear that Wales will remain committed to the NHS model for the foreseeable future, and if, as an EU member in its own right, Scotland did over time shift towards the SHI model that would put the two systems on different paths. Most Western European countries deliver high-quality healthcare with commendable efficiency, albeit at generally higher cost in terms of percentage of GDP spent. However, implementing SHI would almost certainly involve changing from access to services based on residency to more strictly-defined conditional eligibility, greater use of co-payments and increased purchaser pluralism. In a recent international ranking exercise these are among the factors that resulted in France and Germany achieving lower scores for equity, access, and continuity of care compared with the British NHS (Davis et al., 2014). Interestingly, the only territory previously to break away from the UK, the Republic of Ireland, provides free public healthcare only to around a third of its population, pushing many others toward voluntary health insurance as an alternative to user charges in the state system. Ireland has the highest uptake of private insurance in the EU with around 45% of the population covered in this way.

References

Anderson, M., Pitchforth, E., Asaria, M. et al. (2021) 'LSE–Lancet Commission on the future of the NHS: Re-laying the foundations for an equitable and efficient health and care service after COVID-19', *Lancet Commissions*, 397 (10288):1915-78.

Appleby J. (2016) *Is the NHS Financially Sustainable?*, Nuffield Trust Briefing, 22 September. Available at: https://www.nuffieldtrust.org.uk/resource/is-the-nhs-financially-sustainable

Auditor General Scotland (2015) *NHS in Scotland 2015*, Edinburgh: Audit Scotland. Available at: https://www.audit-scotland.gov.uk/publications/nhs-in-scotland-2015

Auditor General Scotland (2019) *NHS in Scotland 2019*, Edinburgh: Audit Scotland. Available at: https://www.audit-scotland.gov.uk/report/nhs-in-scotland-2019#&gid=1&pid=1

Auditor General Scotland (2021) *NHS in Scotland 2020*, Edinburgh: Audit Scotland. Available at: https://www.audit-scotland.gov.uk/uploads/docs/report/2021/n. r_210117_nhs_overview.pdf

Auditor General Wales (2020) *NHS Wales 2019-20: Key facts (Infographic)*, Cardiff: Audit Wales. Available at: https://audit.wales/infographics/nhs-wales-summarised-account

Auditor General Wales (2021*) Rollout of the COVID-19 Vaccination Programme in Wales*, Cardiff: Audit Wales. Available at: https://audit.wales/publication/rollout-covid-19-vaccination-programme-wales

Barnett, K., Mercer, S.W., Norbury, M., Watt, G., Wyke, S. and Gurthrie, B. (2012) 'Epidemiology of multimorbidity and implications for health care, research, and medical education: A cross-sectional study', *The Lancet* 380(9836): 37-43.

Bevan Commission (2013) *Simply Prudent Healthcare: Achieving Better Care and Value for Money in Wales*. Available at: http://www.bevancommission.org/sitesplus/documents/1101/Bevan%20Commission%20Simply%20Prudent%20Healthcare%20v1%2004122013.pdf.

Bevan, G., Karanikolos, M., Exley, J., Nolte, E., Connolly, S. and Mays, N. (2014) *The Four Health Systems of the United Kingdom: How Do They Compare?* London: Nuffield Trust and The Health Foundation

Campbell, F. (2018) *A Matter of Justice: Local Government's Role in Tackling Health Inequalities*, London: Local Government Association.

Davis, K., Stremikis, K., Squires, D. and Schoen, C. (2014) *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally*, New York: The Commonwealth Fund. Available at: https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2014_jun_1755_davis_mirror_mirror_2014.pdf

Department of Health and Social Care (2021) *Transforming the Public Health System: Reforming the Public Health System for the Challenges of Our Times*. London: HMSO. Available at: https://www.gov.uk/government/publications/transforming-the-public-health-system/transforming-the-public-health-system-reforming-the-public-health-system-for-the-challenges-of-our-times
Donovan, O. (2020) 'Senedd roundup: Government writes off £470 million of NHS debt', *Nation Cymru* 7 July. Available at: https://nation.cymru/news/senedd-roundup-government-writes-off-470-million-of-nhs-debt/
Ferris, N. (2021) 'How Wales leads the world in the Covid-19 vaccine race', *New Statesman* 1 June. Available at: https://www.newstatesman.com/science-tech/2021/06/how-wales-leads-world-covid-19-vaccine-race
Forbes, T. and Evans, D. (2008) 'Health and social care partnerships in Scotland', *Scottish Affairs* 65(1): 87-106.
Gartner, A., Gibbon, R. and Riley, N. (2007) *A Profile of Rural Health in Wales*. Available at: https://ruralhealthandcare.wales/wp-content/uploads/2017/08/remote-and-rural-healthcare-updated.pdf
Greer, S. L. (2004) *Territorial Politics and Health Policy: UK Health Policy in Comparative Perspective*, Manchester: Manchester University Press.
Guthrie, B., Davies, H., Greig, G. et al. (2010) *Delivering Health Care Through Managed Clinical Networks (MCNS): Lessons from the North*, Report for NIHR SDO Programme, London: HMSO.
HM Treasury (2020) *National Statistics. Country and Regional Analysis*, London: HM Treasury. Available at: https://www.gov.uk/government/statistics/country-and-regional-analysis-2020/country-and-regional-analysis-november-2020
Holland-Hart, D., Addis, S., Edwards, A., Kenkre, J. and Wood, J. (2019) 'Coproduction and health: Public and clinicians' perceptions of the barriers and facilitators', *Health Expectations* 22: 93–101.
House of Commons (1956) *Report of the Committee of Enquiry into the Cost of the National Health Service* (The Guillebaud Report), London: HMSO.
House of Commons (2019) *NHS Financial Sustainability: Progress Review*, Committee of Public Accounts, Ninety-First Report of Session 2017-19. Available at: https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/1743/1743.pdf
House of Commons (2020) *The UK Response to Covid-19: Use of Scientific Advice*, House of Commons Science and Technology Committee, First Report of Session 2019-21.
House of Lords (2017) *The Long-term Sustainability of the NHS and Adult Social Care, Select Committee on the Long-term Sustainability of the NHS*, Report Session 2016-17, HL Paper 151. Available at: https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf
Hughes, D. and Vincent-Jones, P. (2008) 'Schisms in the church: NHS systems and institutional divergence in England and Wales', *Journal of Health and Social Behavior* 49(4): 400-16.
Hughes, D., Mullen, C. and Vincent-Jones, P. (2009) 'Choice versus voice? PPI policies and the re-positioning of the state in England and Wales', *Health Expectations* 12(3): 237-50.
Ichijo, A. (2004) *Scottish Nationalism and the Idea of Europe*, London: Routledge.
Launer, J. (2019) 'A tribute to Tredegar', *Postgraduate Medical Journal* 95: 407-408.
MacVicar, R. and Nicoll, P. (2013) 'NHS education for Scotland: Supporting remote and rural healthcare', NES Board Paper, August. Available at: https://ruralhealthandcare.wales/wp-content/uploads/2017/08/remote-and-rural-healthcare-updated.pdf
McCrae, M. (2003) *The National Health Service in Scotland: Origins and Ideals, 1900-1950*, East Linton: Tuckwell Press.
Maishman, E. (2021) 'Covid in Scotland: Why are vaccination rates so different between health boards?' *The Scotsman* 11 May. Available at: https://www.scotsman.com/health/covid-in-scotland-why-are-vaccination-rates-so-different-between-health-boards-3231620
Moran, V., Allen, P., Sanderson, M., McDermott, I. and Osipovic, D. (2021) 'Challenges of maintaining accountability in networks of health and care organisations: A study of developing sustainability and transformation partnerships in the English National Health Service', *Social Science and Medicine* 268: 113512.
NHS England (2020) NHS Performance Statistics, January/February, Available at: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/01/Combined-Performance-Summary-January-November-December-data-2020-c7d3g.pdf;

https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/02/Combined-Performance-Summary-February-December-January-data-2020-oi2U9.pdf
Nicholson, E. and Shuttleworth, K. (2020) *Devolution and the NHS*, London: Institute for Government. Available online at: https://www.instituteforgovernment.org.uk/explainers/devolution-nhs.
Office of National Statistics (ONS) (2022) Coronavirus (COVID-19) Infection Survey, UK: 20 May 2022. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/20may2022
Organisation for Economic Cooperation and Development (2016) OECD Reviews of Health Care Quality: United Kingdom 2016: Raising Standards, Paris: OECD. Available at: https://doi.org/10.1787/9789264239487-en
Paterson, B. (2015) 'Questioning the "common sense": Was Scottish independence really an alternative to UK neoliberalisation?', *Capital and Class* 39(3):493-514.
Paton, C. (2021) '"There's the end of an auld sang": farewell to the NHS market', *International Journal of Health Planning and Management*. Available at: https://doi.org/10.1002/hpm.3173.
Pearson, C. and Watkins, N. (2018) 'Implementing health and social care integration in Scotland: Renegotiating new partnerships in changing cultures of care', *Health and Social Care in the Community* 26(3): e396-403.
Powell, F. D. and Wesson, A. F. (1999) *Health Care Systems in Transition: An International Perspective*, London: Sage.
Prior, L. Hughes, D. and Peckham, S. (2012) 'The discursive turn in policy analysis and the validation of policy stories', *Journal of Social Policy* 41(2): 271-89.
Public Health England (2020) The Burden of Disease in England Compared with 22 Peer Countries: A Report for NHS England, London: PHE. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856938/GBD_NHS_England_report.pdf
Public Health Wales (2022) ONS mortality data for Wales. Available at: https://public.tableau.com/app/profile/public.health.wales.health.protection/viz/CovidDashboard_ONSmortality/ONSdeaths
Public Health Scotland (2022) COVID-19 Daily Dashboard. Available at: https://public.tableau.com/app/profile/phs.covid.19/viz/COVID-19DailyDashboard_15960160643010/Dailyupdate
Riley, C. (2016) 'The challenge of creating a "Welsh NHS"', *Journal of Health Service Research Policy* 21: 40-42.
Robson, K. (2011) *The National Health Service in Scotland: Subject Profile*, Edinburgh: Scottish Parliament.
Rossiter, J. (2021) 'What's holding up Scotland's vaccine rollout?', *The Spectator* 4 February. Available at: https://www.spectator.co.uk/article/what-s-holding-up-scotland-s-vaccine-rollout-#
Saks, M. (2010) Analyzing the professions: the case for the neo-Weberian approach, *Comparative Sociology* 9(6):887-915.
Scottish Government (2022) NHS Scotland performance against LDP standards. Available at: https://www.gov.scot/publications/nhsscotland-performance-against-ldp-standards/pages/accident-and-emergency-waiting-times/; https://www.gov.scot/publications/nhsscotland-performance-against-ldp-standards/pages/18-weeks-referral-to-treatment/; https://www.gov.scot/publications/nhsscotland-performance-against-ldp-standards/pages/cancer-waiting-times/
Smith, M. (2018) 'The eye-watering amounts of money the Welsh NHS is spending on private companies to treat patients for them', *Wales Online* 30 November. Available at: https://www.walesonline.co.uk/news/health/eye-watering-amounts-money-welsh-15473532.
Statistics Wales (2020) NHS Activity and Performance Summary, December 2019/ January 2020. Available at: https://www.slideshare.net/StatisticsWales/nhs-activity-and-performance-summary-december-2019-and-january-2020
Steel, D. and Cylus, J. (2012) 'United Kingdom (Scotland) health system review', *Health Systems in Transition* 14(9): 1-150.

Taylor, A. (2015) 'New act, new opportunity for integration in Scotland', *Journal of Integrated Care* 23(1): 3-9.
Vincent-Jones, P. (2006) *The New Public Contracting: Regulation, Responsiveness, Relationality*, Oxford: Oxford University Press.
Wallace, J. (2019) 'Understanding wellbeing and devolution in Scotland, Wales and Northern Ireland', in Wallace J. (ed) *Wellbeing and Devolution: Reframing the Role of Government in Scotland, Wales and Northern Ireland*, Basel: Springer International Publishing.
Watt, T. and Roberts, A. (2016) *The Path to Sustainability Funding Projections for the NHS in Wales to 2019/20 and 2030/31*, London: Health Foundation. Available at: https://www.health.org.uk/sites/default/files/PathToSustainability_0.pdf#:~:text=Our%20projections%20suggest%20that%20longterm%20fiscal%20sustainability%20of,rate%20for%20efficiency%20growth%20of%201%25%20a%20year.
Welsh Assembly Government (2003) *The Review of Health and Social Care in Wales: The Report of the Project Team advised by Derek Wanless*, Cardiff: WAG. Available at: http://www.wales.nhs.uk/documents/wanless-review-e.pdf
Welsh Assembly Government (2006) *Beyond Boundaries: Citizen-centred Local Services for Wales* (Beecham Review Report), Cardiff: Welsh Assembly Government.
Welsh NHS Confederation (2017) *Finance and the NHS in Wales*. Available at: https://www.nhsconfed.org/-/media/Confederation/Files/public-access/Welsh-NHS-Confederation-Finance-Briefing.pdf