

# **THE IMPACT OF POLITICAL DEVOLUTION ON THE UK'S HEALTH SERVICES**

**FINAL REPORT OF A PROJECT TO MONITOR THE IMPACT OF DEVOLUTION ON THE UNITED  
KINGDOM'S HEALTH SERVICES 1999 - 2002**

**Paul Jervis and William Plowden**

**Foreword by John Wyn Owen CB**

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59 New Cavendish Street  
London W1G 7LP

Telephone: 020 7631 8450  
Facsimile: 020 7631 8451

E-mail: [mail@nuffieldtrust.org.uk](mailto:mail@nuffieldtrust.org.uk)  
Website: [www.nuffieldtrust.org.uk](http://www.nuffieldtrust.org.uk)

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# FOREWORD

## DEVOLUTION: 2003

This project has been studying the changes, since devolution, in the ways in which health services are governed and managed, and in which they are accountable to legislatures and citizens, in Scotland, Wales and Northern Ireland. It has documented the ways in which the Scottish Parliament, the Welsh Assembly and the Northern Ireland Assembly have addressed their health agendas, the issues that they have concentrated on, how they have worked, and the strategic direction given by respective Health Ministers, as well as the different administrative efforts used to deliver joined-up government.

On Tuesday 4th March the *Financial Times* carried a headline "England and Scotland are taking different approaches to change. Old-style health service aims to outdo the internal market" and Jennifer Dixon, Head of Health Policy at the King's Fund think-tank wrote "We have a huge natural laboratory in the United Kingdom for studying the outcome of different approaches to reform but no-one seems to be using it". Since 1997, as part of its interest in the changing role of the state as driven by the contradictor)' features of globalisation and devolution, the Nuffield Trust has been supporting a project to monitor the impact of devolution on the United Kingdom's family of health services. This report is a stock-take of where the United Kingdom was in 2002 concerning issues of governance and accountability in health in different parts of the UK and a contribution to mapping some of the changes which took place to April 2002. A year beyond the report, in March 2003, Malcolm Chisholm, the Scottish Health Minister, announced the abolition of NHS Trusts as legal entities and removed the features of an internal market in Scotland. Since 1997 Scotland has been reintegrating hospital trusts into the directly-managed system that preceded the internal market. The *Financial Times* claims that England, in contrast, is rebuilding the market with an emphasis on choice, diversity and competition as drivers for improvement in its healthcare. Furthermore patients in England are being given an increasing range of choices of treatment in NHS hospitals, in the private sector or in Europe. The private sector is being asked not just to build but also to staff a whole set of

treatment centres that will operate under contract to the NHS and the Government is aiming to create Foundation Hospitals - free-standing, not-for-profit, public interest companies aimed at creating a form of public ownership located between public and private sectors.

The Foundation Hospital development has aroused considerable controversy in England, especially among the Government's supporters in the ruling Labour Party. The move is opposed by those who see it as leading to a 'two-tier' health service, but supporters of the policy point to the requirement that the Foundation Hospitals involve their local communities in their governance. This development therefore is fundamental to the issues this project has been investigating. Will the 'localised' governance proposed for Foundation Hospitals in England promote innovation and improved service delivery more readily than the more 'centralised' reforms of governance in the other countries? Will England succeed in capturing the benefits of market-style reforms without their disadvantages? This is just one of the important policy issues that the new 'natural laboratory' of the UK's health services allows us to consider.

As well as considering individual policies and their effectiveness, we should begin to ask 'where will this all end?' What is clear is that diverging health policies within the UK have created a family of health services founded on the values of the NHS which is, as the Chancellor has said, probably one of the "best health insurance schemes in the world" The modernisation programme, however, will challenge the very existence of the NHS and maybe we shall see emerge, to cope with the divergence of home country policies, a national health benefit scheme where the entitlements for UK citizens will be the same but the mode of delivery will be radically different in the various countries of the UK - the transformation of the National Health Service to the National Health Benefit Scheme. Furthermore it is quite clear that no longer is it possible to consider health policy formulation at the UK level. Some aspects of health sovereignty - public health - have already been transferred to the European Union. This will require - as the Nuffield Trust has been advocating for some time - a new Health of the People Bill. Much lies ahead with the prospect of regional assemblies in England, the incorporation of ECHR into UK law and for the skills in inter-government relations to be honed further. Above all this will require a further reassessment of the role and the activities of the most senior officials - elected and appointed - in the Department of Health - the great Department of State concerned with the health of the people of the United Kingdom. The Wanless Report indicated that a fully-engaged future scenario with a reorientation towards health and not just health care would provide significant financial savings to our citizens.

The Nuffield Trust will continue its interest in devolution as part of its programme on the changing role of the state and the machinery of government, and a number of other projects will inform UK deliberations - the History of the Office of Chief Medical Officer, continued rotating meetings of an informal Nuffield Trust Council of the Isles for Health around the United Kingdom. Benchmarking of health policy and performance is essential for the citizen to understand the performance of health institutions across the UK and peer countries in OECD Europe and the Trust will continue support for work on these issues in Cambridge and at the London School of Hygiene and Tropical Medicine.

Devolution, the role of European institutions and globalisation will transform the role of the nation-state in policy making and the management of its affairs. A new constitution for Europe and a higher status for Europe-wide health protection will have a great impact on health strategies in the future. Devolution in Scotland, Wales, Northern Ireland, London and the English regions will offer an opportunity to plan and develop more distinctive health policies on many issues. Globalisation - a process of closer interaction of human activity across a wide range of spheres including economic, political, social, cultural and technological - will put further pressure on the nation-state and its structures by processes or developments that cut across national boundaries and continue to offer both threats and opportunities.

In our Policy Futures document in 2000 the Nuffield Trust recognised that we would see increasing diversification of health policy within the United Kingdom. This report from the Constitution Unit and what is happening all demonstrate that the process is now well under way.

John Wyn Owen CB  
Secretary  
Nuffield Trust  
October 2003

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# EXECUTIVE SUMMARY

## Introduction

1. This is the third and final report of a three-year project. Its aims have been:
  - to assess the impact to date of political devolution on arrangements for governance and accountability in the health services of Scotland, Wales and Northern Ireland (in this last case, to a somewhat lesser extent, due to the resumption of direct rule);
  - to compare the resulting changes with developments relating to the governance and accountability of the England health service.
2. The report first describes the governance and accountability arrangements for the health services of Northern Ireland, Scotland and Wales under the system of administrative devolution that pertained until 1999. It then describes the changes that **political** devolution brought.

## Divergences

3. Some differences between the health systems in the four member countries of the United Kingdom predate devolution. But since devolution other, significant differences have developed in the systems of accountability, and also in the organisation and management, of the four systems.
4. Although there has as yet been no departure from the fundamental values and principles of the National Health Service as enunciated in 1947 (the 'Bevan' principles), it is now more appropriate to speak of the UK's 'family of health systems' than of a single UK-wide 'National Health Service'.
5. In general, there are more similarities between the governance and accountability arrangements for health adopted by the administrations in Northern Ireland, Scotland and Wales than there are between any one of these administrations and England.

6. Many of the policies and approaches in Northern Ireland, Scotland and Wales increasingly seem to be diverging from those adopted in England. It is too soon to say whether, in terms of health outcomes, any of these approaches are 'better' or 'worse' than any of the others.
7. The most obvious changes in the three smaller countries of the UK have been:
  - the shortening of the lines of accountability between elected health ministers, the health service, members of the legislature and the public;
  - the significant reduction in the volume of activities in the devolved administrations for which Whitehall Ministers are directly accountable;
  - the increased attention focused on the wider health agenda, and on health service issues, within the new legislatures.;
  - the policy processes adopted in the legislatures, which are strikingly different from those in Westminster in terms of openness, inclusiveness, and transparency.

These changes increase pressures and scope for political intervention. They affect, not always for the better, the systems' capacity for strategic planning and for "joined-up" policy-making.

### **Changes in England**

8. A number of the more radical innovations concerning the organisation and management of health services, and consequently raising issues of governance and accountability, are being introduced in England. A particular example is the increased use of the private sector in service delivery. There appears as yet to be little desire to replicate such approaches in the devolved administrations. In both Scotland and Wales, the emphasis on traditional central control combined with local accountability to citizens persists.
9. Within the English health care services, the degree of devolution to regions or cities remains very limited. Neither London nor the English regions have, as yet, the autonomy or the powers to develop distinctive approaches at their level.
10. It is too early to say whether the substantial increases in health service spending agreed by the Treasury will continue to be implemented in full, or on the basis of the same priorities, throughout the UK, or whether differences in governance and accountability will be reflected in differences in policy. One possible future source of divergence would be changes in party control in any of the countries.
11. Despite some rhetoric in Scotland and Wales about the importance of better health as opposed to better health services, this has had relatively little perceptible impact so far on the substance of policy.

## The health professions

12. The over-arching challenge to professional bodies in the UK is to find appropriate ways of addressing both *regulatory functions* and *professional interests and issues*. Regulation operates at an all UK level whereas other matters of major concern to professional bodies' members may be determined by the devolved administrations.
13. Devolution has resulted in increased workloads as the different professional bodies respond to the needs to relate to the devolved administrations as well as the UK centre. Especially for some of the smaller bodies, this increased burden has not been easy to resource.
14. Where policy responsibility is devolved, devolution may have weakened the all-UK voice and its impact on policy. Where this has happened, it may have disproportionate effects on smaller specialities.
15. To date, the professional bodies are proving to be resilient and adaptive organisations. Their ability to span the UK and 'national' agendas is likely to be tested increasingly as the devolved health systems emerge further. The major stress may come more from the 'trades union' aspect of professional bodies' roles rather than from the regulatory roles.
16. In future, it seems likely that there will be greater diversity in terms *oiprofessional interests and issues*. The key here for professional bodies is to enable continued exchange of knowledge, experience and best practice across the professions in Great Britain, while allowing greater diversity of activity within each Country.

## The international dimension

17. Major tensions over 'international' health politics have been avoided so far. The Department of Health, in its all-UK role, appears to be reasonably successful in involving the devolved administrations in EU affairs. To date, there seem to have been no major difficulties caused by the operation of the UK policy machinery relating to Brussels.
18. The influence of the European Union in health policy has increased rapidly in the past three years and this process seems likely to accelerate. In future the European dimension is going to figure much larger in the formulation of health policies within the UK. This may well pose greater challenges for the UK policy machinery, and for inter-governmental relations.
19. Despite important discussions in Brussels about a potential future competence for the European Union in health, with a possible impact on member-states' health policies, those responsible for the UK family of health services do not yet appear to have fully recognised the potential significance of this. Possible challenges include whether:
  - European policy will force more similarity, for instance in funding levels or mechanisms, individuals' rights to treatment, the 'rationing' of expensive treatments, and so forth.

- There will be a need to 'rebuild' the UK Health Department to address such developments.

It would be ironic if, just as devolution was seen to be allowing the different countries within the UK to address their health needs in different ways, developments in Europe served to re-impose a straightjacket on policy diversity.

### **Future uncertain**

20. In general the full impact of devolution in the field of health still lies some time in the future. As yet there is no evidence about the degree of tolerance there might be, on the part of voters and of politicians in all countries of the UK, for variations between countries in matters of policy and practice.
21. Political devolution in the UK has altered the landscape of the health services. Devolution has sowed the seeds of many developments; the full impact of these is both difficult to predict and, in any case, lies some time in the future.
22. All the UK health systems face major challenges, stemming in large part from the demographic and economic realities. Despite the recent easing of financial pressures, there remains an urgent imperative for continuing innovation in the face of the challenges.
23. In principle, political devolution has now granted the different countries the ability to develop and own their particular responses to the health challenges they face. Yet there are many shared problems, in tackling which there is a continuing need to share learning and good practice across the different health systems.

# 1. THE DEVOLUTION AND HEALTH PROJECTS

## 1.1 Introduction

This is the third and final yearly report<sup>1</sup> of a project (The Project'), sponsored by the Nuffield Trust, to monitor the effects on the health services of England, Northern Ireland, Scotland and Wales, and on the UK NHS, of the changes in systems of governance and accountability resulting from political devolution.

## 1.2 Background to the Constitution Unit's work on Devolution and Health

The Constitution Unit's interest in Devolution and Health started in late 1997, when John Wyn Owen, Secretary of the Nuffield Trust, commissioned the Unit to investigate:

*the issues arising for the UK National Health Service, and for the health services in Scotland, Wales and England, that may result from political devolution to Scotland and Wales.*

The preliminary results of this investigation were discussed at seminars held in London, Cardiff and Glasgow, and a final report ('the first Report') was published by the Trust in June 1998. (Hazell, R. and Jarvis, P., 'Devolution and Health', The Nuffield Trust, June 1998).

The first Report noted that the processes of change in the NHS had been composed of two parallel agendas, with the introduction of political devolution being superimposed on the

1. The first report, published in February 2000, covered developments in the calendar year 1999. The second report, published in June 2001, covered the period January 2000 - March 2001. In terms of substantive reporting of developments, this report covers the period April 2001 - end May 2002, the extended time period having been adopted partly to allow discussion of the health spending plans of the UK government announced in the 2002 budget, and the Wanless report on health service funding published simultaneously with the budget. The analysis presented here also reflects subsequent discourse, particularly in England, although formal monitoring activities ended in April 2002.

health service reforms introduced by the new Labour government. The changes in the health services had been developed within the system of administrative devolution to Scotland and Wales that existed in 1997. Although the three countries shared a common need to improve their populations' health and address health inequalities, and faced many common problems, it was suggested that it would be unreliable to use the then current proposals for health service reform in England, Scotland and Wales to assess the potential for greater policy divergence in future. (Note: Northern Ireland was not covered by the research at this stage.)

The first Report found no evidence that the core values and principles which underlie the NHS in England, Scotland and Wales were likely to be adversely affected, or indeed much changed, by political devolution to Scotland and Wales. If the 'model' of the 'NHS' was described in broad terms as a service funded by general taxation, accessible to all, and free at the point of delivery, then there was little evidence of different models of health care emerging in the different countries. Without threatening fundamental principles and values, however, there was scope for considerable variation in terms of policy, organisation and management. Even if the same general model of health care were to remain in use in the three countries, it was suggested that there would remain room for considerable innovation and experimentation in governance, organisation, management and service delivery. There were signs that devolution might threaten some of the UK-wide professional and policy networks through which information and learning was disseminated. There was a need therefore to ensure that learning from policy and organisational innovation and experimentation continued to be shared across the UK's health services.

The research also indicated a number of issues over which, post-devolution, there might be tensions between the constituent countries, or between different countries and the United Kingdom government. Among the issues identified were:

- The potential for differences over human resource issues, and aspects of regulation.
- Possible difficulties in agreeing mechanisms for determining the funding of health services - the operation of the 'Barnett formula' and any replacement.
- The scope for disagreements about links with international bodies, especially the European Union.
- Possible dissatisfactions with the manner in which decisions about 'reserved matters' would be made.
- Tensions arising from the need to collaborate in areas such as education and training.
- The potential for disagreement over the modus operandi of the (mainly UK-wide) professional bodies.

The first Report also pointed to the possible benefits from devolution for health policy and the management of the health services in Scotland and Wales. In responding to the health agenda, they had some advantages over England. The 'policy villages' in Scotland and Wales, with tight political and professional networks, could make for quicker and easier

agreement over policy and strategy. Further, it was claimed that health gain policies should be easier to implement because the small scale in Scotland and Wales would make it easier to work across departmental boundaries.

### **1.3 The aims of the Devolution and Health Monitoring Project**

The aim of the current project, for which this is the final report, has been to build on the earlier work on devolution and health by monitoring, now that political devolution has become a reality, the effects on the different health services, the professionals and managers who work within them, and the other 'stakeholders' with whom they need to work. In contrast to the earlier study, which did not investigate the situation in Northern Ireland, this monitoring project covers all four countries of the United Kingdom.

We have always maintained the view that, from the perspective of citizens as well as of health professionals, the real test of devolution will be its effect on the health of the people of England, Northern Ireland, Scotland and Wales. Will the arrangements that have now become established enable the specific problems of Wales, Scotland, and Northern Ireland - including their relatively poor health status - to be addressed more effectively than in the past? And how will the NHS in England develop in comparison with the health services in these relatively smaller jurisdictions?

The problem, in posing these questions, is that changes in outcomes may take many years to work their way through. The more immediate impacts of devolution have been on the processes of governance and accountability within which the health services operate. It is on these processes that the Project has focused. Of course, we have not been uninterested in the specific content of health policy. We have asked, for example, whether the countries are adopting different approaches to primary health care, or whether 'evidence-based medicine' is being implemented in differing ways, but our primary focus has been on the policy process and associated issues of governance and accountability.

We have been attempting to observe:

- the composition and activities of the Health Committees in the Scottish Parliament, Welsh Assembly and Northern Ireland Assembly;
- the issues they choose to examine and the way they function;
- the strategic direction given by the respective Health Ministers;
- the governance arrangements established for health service organisations (Health Authorities and Boards, hospital and primary care trusts, and other organisations involved in service planning and/or deliver?);
- the democratic accountability of these structures;
- the different methods used by the new administrations to deliver 'joined up government', and the effectiveness of these;
- the budgetary and audit arrangements that are established and the ways they operate.

Given the changes which devolution has brought to the policy process at UK level, we have also been working to monitor, in the context of health policy the conduct of 'inter-governmental relations' (the transactions between the devolved administrations in Belfast, Cardiff, and Edinburgh and between them and the United Kingdom government in Whitehall). Specifically, we have investigated:

- arrangements for intergovernmental co-ordination and planning between the four health services;
- the inter-governmental arrangements at the all-UK and EU level.

We hope that this work will contribute to assessments, inter alia, of:

- How the Scottish Parliament and Northern Irish and Welsh Assemblies influence the development of health policies and strategies. Whether their activities focus on strategic leadership or whether tactical issues of audit, supervision and accountability dominate.
- Whether, and how, Scotland, Wales and Northern Ireland, as 'policy villages', prove more effective at delivering 'joined up government' in the area of health and health care.
- How UK-level health policy is conducted, in respect of European and other international matters, and in those areas which are 'reserved'. Whether the principle, or the detail, of 'reserved' powers comes under pressure, and if so how.
- How the UK professions respond to devolution. How, if at all, the various UK health and health-related professional bodies adjust their governance structures and operating methods to reflect the post-devolution situation. How satisfactorily professional bodies' involvement in UK-level policy development is secured post devolution.

At the outset of the project, we had hoped in the medium term to produce information about:

- how the debate about funding for Northern Ireland, Wales, Scotland and the English regions developed, and the implications for health;
- whether the rationing debate developed further in any of the countries and whether Northern Ireland, Scotland and Wales devise more effective, and more publicly acceptable, ways of addressing 'rationing' decisions;
- whether the English health service could play its full part in the development of regional economic and other strategies in the English Regions and London ;
- whether the new English regional institutions would be able to engage appropriately with the debate on health policy, priorities and resource issues.

Our intention has been to provide a commentary on the effectiveness of these devolved arrangements in delivering improved health and health care in a devolved United Kingdom. We recognised that these were ambitious objectives for a project with relatively limited

resources. Moreover, the issues we were addressing did not lend themselves to any single, simple, research methodology. To address them, we accessed multiple sources of information and in particular endeavoured to link closely with the policy and practitioner communities in the four countries. To this end, we worked with research partners in Northern Ireland (Department of Politics, Queen's University Belfast and Democratic Dialogue), Scotland (initially the Scottish Council Foundation and latterly Professor Kevin Woods of the Department of Public Health, Glasgow University) and Wales (initially The Institute of Welsh Affairs and latterly Dr Rhiannon Tudor Edwards of the Centre for the Economics of Health Care, University of Wales, Bangor).

We looked to each of our partners to maintain a 'health network' which included representatives of all the key 'stakeholder groups', including those in the political arena (national and local), national and local government, health service managers, health professionals, academics and lay members involved in the governance and management of health. We are most grateful to all our partners for their enthusiastic contributions to the project, and for their informative monitoring reports, all of which will remain accessible via the Constitution Unit's Devolution and Health website ([www.ucl.ac.uk/constitution-unit/d&h](http://www.ucl.ac.uk/constitution-unit/d&h)). Developments in England, including those in the English regions and London, have been monitored by the Constitution Unit team, which also worked to monitor inter-governmental relations in health.

#### 1.4 The aim of this final report

The first purpose of this final report is to take stock of the position after just over three years of devolution, in the spring of 2002, relating to issues of governance and accountability in health in the different parts of the UK. Perhaps more importantly, we then want to try to take a forward look, and identify what are likely to be some of the key issues to be addressed in the different countries over the next few years.

The first Annual Report of the Project (J<sup>ERV</sup>'s, P. and Plowden, W 'Devolution and Health : First Annual Report of a Project to monitor the impact of devolution on the United kingdom's health services', Constitution Unit, UCL, February 2000) contained lengthy accounts of developments in Northern Ireland, Scotland and Wales, contributed by the monitoring partners in those countries, together with sections on London, the English Regions, the Professions and Inter-governmental relations. Since the beginning of 2000, however, the monitoring teams have submitted quarterly reports and these were posted as they were received on the Devolution and Health web-site, , where they will remain available. Because of this, we are not including here any detailed accounts of recent developments in the different countries.

We revisit below some of the issues around London and the English regions, where developments have been somewhat slower and where less material has been posted on the web-site. Finally, we address issues of intergovernmental relations in some detail.



## **2. HEALTH IN THE UK - WHERE ARE WE NOW? VARYING INTERPRETATIONS**

### **2.1 Introduction**

To start our account, we offer some subjective reflections and impressions, some four years on from the first Report . In doing this, we will highlight some of the main unexpected developments, as well as those which had been expected. In the following sections we will first offer a brief description, and then analyse, some of the issues on which we reflect here.

A remark much quoted at the time of the first Report, and certainly one with which we agreed, came from the former Secretary of State for Wales, Ron Davis, who described devolution as a process not an event. If so, the UK is still in the early stages of that process, so the learning clearly hasn't finished. But the process has been going long enough to enable us to observe the 'trajectory' along which things are developing. One question - to which we will return later - is whether that trajectory is likely to change.

Taking the possible problem areas post-devolution identified in the first Report, and mentioned in the previous section, perhaps the most striking thing is that relatively few of them seem to have given rise to major difficulties - at least so far. Perhaps this is because the Department of Health 'centre' prepared very well for devolution. Or perhaps the difficulties have arisen, but have been kept out of sight of external observers and the general public.

But we should also note that most observers predicted that there would be relatively little divergence, and few disagreements, when the same political party was in power in Whitehall and the devolved administrations. Labour has had to enter coalitions in Scotland (which was always expected because of the arithmetic of proportional representation) and Wales (which was totally unexpected and was generally assumed to be the result of Tony Blair's intervention in the election of Ron Davis's successor). Nevertheless, effectively the same party has been in power, or sharing power, throughout Great Britain if not in the

whole United Kingdom, because of the very different position in Northern Ireland. This means that the devolution settlement has yet to be subject to its greatest stress, that which would come from governments of different political colour holding power in the different countries. One significant event, the Scottish decision on free personal care for the elderly, which we describe below, exemplifies not only the possibility for policy divergence between the UK government and the devolved administrations but also the strength of the pressures to inhibit such divergence.

This does not mean that difficulties have been entirely absent. Our own interviews and discussions with key actors in the different countries confirm that it hasn't all been plain sailing. There can be tensions in operating the new devolved policy systems. A continuing source of tensions, and not the least significant, relates to the potential for decisions by the English NHS to create problems for the other countries, by virtue of England's size, the power of the London-facing media, and so forth.

There have also, inevitably, been the 'events' so graphically described in Harold Macmillan's famous response to being asked what most worried him. There have been many developments which we did not anticipate, including:

- The number of different 'governments' in Scotland and Wales. (In Wales, there have been two different First Secretaries, the second of whom first led a minority-administration and later entered a formal coalition with the Liberal Democrats; in Scotland there have been three different First Ministers. Each change in each country has resulted in some changes in policies and/or priorities, affecting health among other policy areas. As well as these unexpected changes of government that have taken place in Edinburgh and Cardiff, there has been an almost total change of personnel in the senior levels of the civil service responsible for the Scottish and Welsh health services.)
- Finance - the commitment by the Prime Minister to raise UK health spending to the European average, and the consequent developments concerning the funding of the health services and the performance expectations identified in return for the additional funding.
- The growing impact of the EU in health, which we will describe in some detail later.

So, where had we got to after three and a half years of devolution?

In an era when 'evidence-based' approaches to policy are in vogue, it sometimes is surprisingly hard to get agreement about what the available evidence indicates. For example, few will disagree that there are now some clear differences in governance, organisation and management of the health services across the four countries. (The position with respect to policy is less clear.) However, people do not always agree about the causes of these differences. If what is happening in Scotland, Wales and Northern Ireland differs from what is happening in England, one key question is 'Are these differences a result of devolution, or are they driven by something else?'

It may be, for example, that political devolution has allowed the different national identities, cultures, and values within the UK to be expressed in the different health

services in a way that was not possible under administrative devolution. The first Report endorsed the common claim that Scottish society has more 'communitarian' values than that of England. Some have pointed out that this claim is not so far validated by those surveys that have been carried out. Without firm evidence for the existence of more 'communitarian' cultures in Scotland and Wales than in England, this hypothesis becomes difficult to test.

There are still some people who attribute what is happening merely to the continuation of trajectories that had been established in the period of administrative devolution. (As the first report described, before political devolution, the health services in Northern Ireland, Scotland and Wales were locally organised and managed). To ascribe differences to developments that had their roots in the period of administrative devolution is not to diminish their importance, of course; it simply cautions us that establishing causality is difficult.

## 2.2 Main developments and issues

Six groups of developments seem to us worth emphasising:

- there has been divergence - but in terms of governance, organisation etc. rather than in the fundamental values of the health services in the different countries.
- more differences appear to have developed in the *process of policy formation* than in the *content of policy*.
- However, at least at a rhetorical level the policy focus in Scotland and Wales seems to be more clearly on 'health' rather than just 'health services'. England has yet to develop such a clear focus on health. In England the dominant and continuing concern has been the need to improve the provision of health care by reform/modernisation of the health *service*.
- the processes of Inter-governmental Relations (IGR), though largely hidden from public scrutiny, are growing in significance.
- European policies are becoming increasingly important for the UK health systems, and are likely to bring significant challenges.
- 'The Department of Health, which we observed in the first report acted in a variety of roles, and which initially seemed reluctant to acknowledge the loss of most of its "all-UK" responsibilities, is now much more clearly acting as the English Health Department'<sup>2</sup>.

The fact that we report relatively few major problems in the operation of UK health policy post-devolution might suggest that there has been a fairly rapid 'growing up' in the administrations concerned, and that UK systems and processes are working relatively well. But what of the future, and what are the main themes emerging from the project?

2. Our analysis here is close to that of Kevin Woods: see 'Health and NHS Policy in the UK 1997-2002' in Adams and Robinson (eds) *Devolution in Practice* (IPPR, London, 2002)

We have already discussed the difficulties of establishing causality in the developments we have been monitoring. Taking some liberties for the sake of alliteration, there are five more issues which we want to discuss briefly here. They are:

- Culture and Conduct
- Connection
- Cash
- Collaboration and the Centre
- Cooperation
- The Centre

### **2.3 Culture and conduct**

The phrase 'Culture and conduct' reflects the ideas about openness, transparency and inclusiveness which are being promoted in the devolved administrations. The policy process in Scotland and Wales is now markedly different from that in Whitehall. There are both 'technical' and cultural differences. Technically, the fact that the devolved administrations operate with single decision-making chambers (are 'unicameral') means that the processes of legislation and legislative scrutiny are very different (i.e. there is no equivalent to the House of Lords in the policy process).

In Scotland and Wales, much has been done to re-assert the importance of democratic accountability. Even if there has not yet been the 'bonfire of the quangos' that was promised, governments there have taken steps aimed at diminishing the 'democratic deficit' in the area of health services. (The situation in Northern Ireland is more complex, and we discuss some of the Province's particular challenges below.)

Culturally, the devolved administrations have embraced the principles of openness, transparency, and inclusiveness in the policy process. This is a style very different than that which still pertains in Westminster. It has the potential to lead to very different outcomes. We cannot yet say whether it is 'better' in terms of delivering health outcomes. Indeed, if anything, this new culture may be delaying or making more difficult the taking of 'tough' decisions. We cite below some evidence for this in the case of Scotland. This is an area for future scrutiny, as is any tension between Whitehall and the devolved administrations as a result of the different 'policy cultures' that are developing.

There have been significant structural changes in the 'English' health department - which now is happy to admit that its focus is on England, having initially on several occasions given the impression that it spoke for the whole UK. However, while the Department is now clearly seen as acting for England in the vast majority of its roles, it still often talks of 'the NHS' rather than 'the English NHS'. Clearly, there is still scope for cultural change here.

### **2.4 Connection**

We use the term 'Connection' to denote the challenges of 'joining up' government and the policy process, an area in which we have some evidence of a potentially major surprise and

a counter-intuitive finding. The assumption, described in the first Devolution and Health report, had been that 'joining up' would be easier in the smaller 'policy villages' of the devolved administrations. A possible sign of this has been that the policy focus in Scotland and Wales seems to be more clearly on 'health' rather than simply on 'health services'. However, some of those close to the administrations in those countries report that 'joining up' is as elusive as ever, and 'functional chimneys' still persist in the Scottish Executive and National Assembly for Wales; indications from recent discussions within the project suggest that joining up government in the devolved administrations may be becoming harder rather than easier. We return to this theme below.

## 2.5 Cash

'Cash' refers to the developments about health service finances. The initial Devolution and Health report identified unease in the devolved administrations about any future re-negotiation of the Barnett formula. This has been resisted so far, but the rapid increases in (English) public expenditure have both generated significant additional sums for the devolved administrations but also accelerated the 'Barnett squeeze'. That is, the Barnett formula was designed to bring about over time a convergence in per capita public expenditure. This convergence happens most rapidly when growth in English public expenditure is highest. In the last two years the effects of the Barnett squeeze have become significant for the devolved administrations.

The fine details apart, the principle of the formula is extremely simple. The starting point is that average per capita public expenditure in Scotland, Wales and Northern Ireland is considerably higher than in England. The aim of the formula is to reduce these disparities. Its effect is that changes made in the level of resources provided to Scotland, Wales and Northern Ireland are linked, arithmetically, to the changes made in resources provided to English spending departments. To put it simply, "the formula ensures that those areas that enjoy higher levels of per capita spending receive slightly lower proportionate rises in spending than those with lower levels of per capita spending." In the case of health the operation of the Barnett formula had the consequence that whereas total expenditure on the NHS, England, was projected to increase by 61.7 per cent over the period 2002-03 to 2007-08, the increase for Scotland, Wales and Northern Ireland together was 55.7 per cent (Spending Review, 2002, Table 7.1). Initially, it had appeared that pressures for departing from the Barnett mechanism - or at least revising it radically - were most likely to come from the English, in protest about the significantly better per capita funding the Scots, and to a lesser extent the Welsh, were receiving. But the effects of the Barnett squeeze are so significant that it may in fact be the devolved administrations who first press for change. In other words, it has not been constitutional change per se that has provoked calls for the revision of the Barnett formula, it has been the effects of the increased spending. And the pressures for change are coming from unexpected quarters, the devolved administrations rather than England.

The most significant development in relation to finance has been the publication of the Wanless report ('Securing our future health : taking a long-term view' HMSO, April 2002),

commissioned by the Chancellor of the Exchequer, and its acceptance as the basis on which future decisions about health funding should be based. This report, the purpose of which was to review the long-term trends affecting the health service in the UK and to determine the resources needed for a high quality service, appeared to take a relatively narrow view of the scope for 'regional' differences. As we shall report, Wanless allowed for national differences only where these reflected "objective" characteristics - demography, geography, economic situation, health status; he was not concerned with the possible impact of culture and values, or, consequently, of politics.

## 2.6 Collaboration and the Centre

The terms 'Collaboration' and 'the Centre' denote two sides of the same coin. The first Devolution and Health report was almost wholly descriptive. The one bit of 'theory' or modelling attempted was the use of a corporate sector analogy to examine the relationship between the devolved administrations and the 'UK centre'. While the report identified desires in the devolved administrations for a more explicitly 'federal' arrangement, the reality was that Whitehall was the 'corporate headquarters' for the UK health services.

This was identified as a potential cause for concern, particularly in the context of relationships with Europe. This was an area where, it was claimed by many of those interviewed for the First Report, the involvement of Scotland, Wales and Northern Ireland had not been handled well in the past by the Department of Health. It was thought that, post-devolution, there would be the potential for major tensions to arise around 'international' health policies and politics. But so far such difficulties appear to have been avoided. However, the importance of Europe in health policy has increased rapidly in the past three years, and this process seems likely to accelerate. As we discuss in more detail below, recent EU documents comment:

*".... it is clear that health policy at EU level is still in its infancy and it has not yet been given the priority it requires in policy-making within EU institutions. . . . The development of a proactive and broader health policy under which the main health interests will in future be dealt with and co-ordinated is a priority for the immediate future."*

It is likely therefore that the UK will need in the near future to engage more actively in discussing European health policy. Will this put new stresses on the policy process? If devolution has begun to allow the national identities, cultures, values, to be expressed in the delivery of health policies (and health service policies), will this continue? Will development of European policies force more similarity? If so, what does that mean for the 'UK centre'. Will there be a need to 'rebuild' a different type of UK Health Department, with a changed remit and modus operandi? As a result, will IGR in health become more fraught? And what then might be the implications of the lack of transparency and accountability of some of the IGR processes?

## 2.7 Cooperation

Cooperation sits alongside these issues. In the Scandinavian countries, the Nordic Council

supports collaboration and co-operation. The Council was created in 1952 as an informal body of parliamentarians from the Nordic countries. The aim initially was to consult on practical matters. Over time, Nordic schemes of co-operation have gradually grown to cover a range of different policy areas, and the Nordic Council now supervises the work of more than 40 specialised agencies and has a growing body of legislation directly applicable to the citizens of the different countries.

An analysis by the Constitution Unit of the workings of the Nordic Council and its committees reports that the Nordic schemes of co-operation have focused on relatively low profile issues, and have been unsuccessful when they have attempted to reach agreement on more controversial matters (such as nuclear power) or where they have contemplated more wide-ranging schemes of co-operation. (Qvortrup, M, 'The politics of Neighbourly Co-operation : Nordic lessons for the Council of the Isles', Constitution Unit, UCL, 1998). There are signs that this sort of voluntary co-operation is starting to happen in some areas within the four UK health services - for example in evidence-based medicine. Will this trend develop, and if so how?

## **2.8 The scope for learning**

One final question on which to reflect is whether we can learn anything more generally about devolution and the policy processes from what is happening in health. Is the case of health so different that the lessons do not generalise? Some argue that the salience of health, and its centrality to issues of national identity, mean that it will always have to be managed with a considerable degree of central control. We discuss this further below.

As we observed in some of our annual reports during the monitoring project, all involved have faced very steep learning curves; in terms of the life times of institutions etc. these are still very early days. There is also considerable inertia in the system: even where differences in approach are starting to develop - for example between England and Wales over consumer representation, or between England and Scotland and Wales over reliance on the private sector - these do not lead to immediate divergences in service deliver)', let alone in health outcomes. This needs to be remembered, particularly by those who may have been expecting that by now we could point to some sensational variations between the several national health services. It is in this spirit that we now address some of the key developments reported by our partners, or identified by us, since the onset of political devolution. We first describe the main developments and then develop our analysis.



## 3. GOVERNANCE AND ACCOUNTABILITY: DIVERGENCE DEVELOPS

### 3.1 Introduction

In our first report we said (p 10) that we anticipated that changes in health outcomes would take many years to work through. We suggested that the more immediate impacts of devolution would be on the processes of governance and accountability within which the health services of Scotland, Wales and Northern Ireland operated. In speaking of "governance" we had in mind the activities of the several Health Ministers, the arrangements which they would establish for managing health authorities and other bodies, methods of delivering "joined up government", budgetary and audit arrangements.

The notion of "accountability" has for long been relevant, and contentious, *within* the NHS: Ministers and their civil service advisers on the one hand, and health professionals - managers and clinicians - on the other tend to have differing views about how far, and for what, the latter group are accountable to the former. To turn it round, the issue is how far the former group can give instructions to the latter - and about what. In a recent report<sup>3</sup> Kevin Woods has described this as *administrative* accountability. The definition and redefinition of this relationship has been a constant theme in successive reorganisations of the UK NHS, and it is of concern to this study.

More important, however, is what Kevin Woods calls *political*, or *public* accountability. By this we mean the range of ways through which those responsible for the NHS, and in particular Ministers, can be required - by citizens, taxpayers, patients or their representatives - to account for their use of public funds, to give an account of their activities and to explain and/or justify these. We were thus interested in the three-cornered relationships between Ministers of Health, health services, and elected representatives. We were interested in the activities of the new assemblies and, in particular, in the composition and activities of their new Health Committees. To this list we might have added

3. See Woods, K., op. cit.

arrangements for public scrutiny and oversight of health service providers, such as the Community Health Councils in England and Wales, or other arrangements such as "patients' forums". In reviewing developments in the new administrations we naturally expected to be interested in any contrasts with the position in England, and in any relevant developments there.

It is worth underlining the point that, in its fullest sense, the notion of accountability includes two further possibilities. The first is the possibility of *sanctions*. Internally, within an organisation, a manager at one level who is ultimately accountable to the chief executive accepts that poor performance may lead to loss of seniority or of salary, or dismissal. Externally, in western representative democracy, true public accountability requires elected officials to accept responsibility for their actions and those of their officials, and, where required, to give a full account of these to the public; they must also recognise that, if this account is deemed to be unsatisfactory, they may face public criticism, electoral defeat and loss of office. The second possibility is that of *control*. If those to whom an account is given do not like the policies or processes thus described, the logical next step is for those giving the account, and who wish to avoid censure or loss of office, to make appropriate changes.

There is an alternative form of accountability, through the operation of market mechanisms. Here, suppliers of services are, in a different sense, accountable to their customers (actual or potential). Customers choose between suppliers on the basis of experience and/or information; suppliers considered unsatisfactory must improve their services if they are to survive in the market-place. The Labour government came to power in 1997 pledged to overturn the Conservatives' experiments with market mechanisms in health care. Changes began to be introduced in the period of administrative devolution. In the politically devolved administrations, there is no sign of any move to re-experiment with market mechanisms. In England, the government has continued to use anti-market rhetoric although, as expert commentators have reported and as we discuss further below, implicitly market-type mechanisms are being proposed. The involvement of private sector healthcare providers to deliver services to NHS patients is one major aspect of this, and currently is an extremely contentious issue, both outside and within the UK government.

### **3.2 The NHS before devolution:**

#### **3.2 (a) Governance**

Even before devolution there were some interesting differences between the executive structures in England, Scotland, Wales and Northern Ireland. By the time of devolution, in 1999, the Labour government had already made changes in the arrangements which it had inherited from its Conservative predecessors.

The arrangements on the eve of devolution were as follows.

In *England* the Secretary of State for Health and Social Services presided over the Department of Health and Social Services, which was responsible for policy under a civil service permanent secretary. A separate NHS Executive, with its own chief executive, was

responsible for managing the NHS, through 7 Regional Offices and, below them, 100 Health Authorities. In nearly every case, these were co-terminous with other local authorities. In general practice, the mixed system of fundholding and non-fundholding practices was being changed. GP fundholding was being abolished, to be replaced by primary care groups and primary care trusts.

In *Scotland* the Secretary of State for Scotland, a member of the UK Cabinet, was the political head of the NHS in Scotland, part of the conglomerate Scottish Office. In contrast with England, the department's civil service head was also the head of the Management Executive of the Scottish Health Service. This had 15 Health Boards, responsible also for the family practitioner services. Board members were appointed by the Secretary of State. There were also 14 Acute Hospital Trusts, 13 Primary Care Trusts, 1 combined Trust and arrangements specific to the Island boards.

In *Wales* the Ministerial set-up was identical to that in Scotland, with the Health Department being part of a conglomerate department headed by a Secretary of State. However, as in England, the civil service head of the Welsh Office Health Department was a post separate from that of the Director of NHS in Wales, who was appointed by the Secretary of State. Both were members of an executive committee responsible for managing the service. Until the spring of 1999 all the top staff in the WOHD were career civil servants. Following an analysis commissioned from a former DoH permanent secretary, which contained some critical comments, a new NHS Directorate was set up in April; key posts were advertised with the aim of attracting people with first-hand experience of the NHS. There were 5 health authorities, whose members were appointed by the Secretary of State. In April 1999 mergers of NHS Trusts reduced their numbers from 25 to 16, and those of Ambulance Trusts from 5 to 1.

*Northern Ireland* was different again. As in Wales, the Department of Health and Social Services, and the health service Management Executive, had separate heads, both answerable to the Secretary of State. The executive structures for delivering health services predated direct rule. A report of June 1970 had recommended that health and social services should be administered through a system of four "area boards". Members of the boards were to be experts in relevant fields, appointed by the minister concerned, plus some local authority representatives (whose posts were abolished in 1991). Since the introduction of direct rule in 1972 appointments had been made by the London-based Secretary of State. Since 1991 there have also been four health and social service councils to oversee the boards. Council members are appointed by the DHSS: 40 per cent from the relevant local authorities, 30 per cent represent voluntary organisations and community groups and 30 per cent from people considered by the DHSS to have an interest in the provision of health and social services.

### **3.2 (b) Public accountability and oversight**

Before devolution, legislative oversight of the NHS was, of course, limited to the UK Parliament in London, whether operating in plenary mode or through the relevant specialist select committees of the House of Commons (including primarily the Health -

earlier, Social Services - Committee, but also the Public Accounts Committee and the Select Committees dealing with the affairs of each of the other three countries). Select committees played no part in the legislative process, legislation being handled by a quite separate system of "standing" committees. Direct public accountability was thus highly centralised and "top down", being through the Secretary of State for Health and Social Services or the three territorial Secretaries of State. Before devolution the former appeared in the House of Commons to answer parliamentary questions about health matters. His territorial colleagues - who were simultaneously answerable for all the other aspects of the governance of 'their' fiefdoms - appeared from time to time. The Scottish Affairs Committee looked at health only once in four years. It is worth emphasising the familiar fact that in contemporary Britain the executive, through a disciplined majority party, normally exercises almost total control over the legislature. Policies are made by the government of the day and usually modified only at the margin as the result of discussion in Parliament.

In health there was in England and Wales one other, very limited form of local accountability to the citizen. Since 1974, a voice for patients in England and Wales had been provided by Community Health Councils (CHCs), one per health authority, whose members were nominated by local authorities, voluntary organisations and regional offices. Health Authorities were required to consult with CHCs on any proposed changes in service deliver)<sup>7</sup>. The arrangements almost guaranteed an adversarial relationship between the two bodies, and effective partnerships were relatively rare. There was an equivalent institution to the CHCs in Northern Ireland, the Health and Social Service Councils; 40 per cent of their members were district councillors, appointed by the DHSS after consulting the relevant local authorities. Accountability for activities at intermediate levels, specifically the regions, was only through Ministers in Parliament. In England there was no role for local government in these arrangements.

Health expenditure, services and policy were monitored by the National Audit Office (reporting to the Public Accounts Committee) and (in England and Wales only) by the Audit Commission, to whose initial focus on local government the NHS had been added in 1990.

### **3.3 Health services post-devolution**

#### **3.3(a) Changed arrangements**

The major change following devolution in arrangements affecting both governance and accountability of course has been the establishment of a parliament in Edinburgh and assemblies in Cardiff and - repeatedly interrupted by the resumption of direct rule - Belfast. This also meant the creation of 'ministerial' posts whose holders were directly answerable to these local legislatures, and to their new specialised committees.

The revised arrangements, which we now describe, should be considered in the context of the different population sizes of the four separate jurisdictions. The Scottish Parliament has 129 members for a population of 5 million, the Welsh Assembly 60 members for a population of 3 million, the Belfast Assembly 108 members for a population of 1.7 million.

(In contrast, England with its population of 50 million is represented by 529 MPs in the House of Commons.) Scotland, Wales and Northern Ireland also retain their Westminster MPs with local constituencies, although these individuals have no locus in health policy decisions in their 'home' countries. (Although they can, of course, vote on Westminster legislation affecting the English NHS.) In the case of Scotland, where Westminster legislation does touch on devolved matters, the so-called "Sewell convention" provides that such legislation must be endorsed by a resolution of the Scottish Parliament - which, in general, has happened more often than anticipated.

The members of the Parliament and Assemblies can both scrutinise their respective executives and handle draft legislation; in Scotland and Northern Ireland they can, additionally, initiate legislation of their own.

*Wales* - One result of advertising the top posts in NHS Wales was that the new director was a long-time senior NHS professional. The Welsh health plan, published in February 2001, proposed to abolish the five existing Health Authorities and to replace them with 22 Local Health Boards, coterminous with local authorities. (This change - which required Westminster legislation - took place in April 2003.) There were also to be 15 Hospital Trusts, 12 Health Partnerships and three regional offices. The Boards are being given powers, duties and obligations to become commissioners as well as providers of health care. Board members will include representatives of local authorities, both to strengthen local accountability and to reflect a new emphasis on joint working.

Since Boards' role as commissioners of secondary care services would require sufficient critical mass and expertise to ensure effective services it was proposed that secondary care commissioning responsibilities should be carried out by "consortia" of Boards based on the three "health economies" of north, Mid-West and South-East Wales.

The Health Secretary' argued that abolishing authorities would remove "an unnecessary tier of administration" and would bring resources and decision-making powers closer to local populations; there would be a direct line of accountability between the Assembly and the local Boards and Trusts. There was much Parliamentary criticism, including by Coalition partners the Liberal Democrats, of this multiplicity of bodies. The Health Secretary' yielded to this pressure by agreeing to abandon the consortia proposal; instead some 10-15 "local partnerships" were created, bringing together for 'purchasing' economies of scale 2 Local Health Boards, two local authorities and one NHS Trust.

In Wales, Health Secretary Jane Hutt, who has served continuously since 1990, has appeared before the Assembly ever)' 4 to 6 weeks. A large number of Assembly Questions have been tabled and answered. The Health and Social Services Committee, which has 9 members from four parties and is chaired by a Liberal Democrat, has met twice a month. The Health Secretary has reported to the Committee once a month, accompanied by up to 8 officials, in sessions lasting some 45 minutes. The Committee has investigated a number of major policy issues, e.g. waiting lists, cancer services. Like other Assembly committees, the Committee has also identified its own priorities for the health budget; for 2000-01 the Minister provided a paper outlining how far she had been able to follow this advice.

It took the Committee some time to get round to scrutinising authorities and trusts; the first authority appeared before the Committee in June 2000, and in 2000-01 a total of one authority and two trusts were examined.

For the Committee, problems were seen as deriving from its misperception of its own role, and work overload. One result of the latter has been that the Health Secretary has simply delivered her reports without any substantive discussion. (In general, scrutiny by Assembly Members seems to have been more robust in plenary sessions than in Committee.) The Conservative spokesman on the Committee commented (Assembly Record, 9 May 2000):

"When the Assembly came into existence, it was clear that the Committees were to be involved in an innovative level of policy development. However, that led to a dramatic overload of Committee work. We became bogged down in detail; important strategies received fleeting attention... Mixing policy development and scrutiny in the same Committee continues to be problematic. The Committees are at their most effective when they are scrutinising.

Overload continued to be a problem, and the Committee discussed its difficulties in October 2000. There were also criticisms of the chair for the alleged ineffectiveness of the Committee in its relationship with the Health Secretary. In May 2001 the Conservative spokesman recommended that the Committee should abandon its effort to scrutinise the administrations policy proposals and should concentrate more on long policy reviews:

"Piecemeal involvement in policy development results in Committees being submerged in detail without any obvious added value. I find it curious that the Assembly, as an elected institution, comprehensively delegates authority to the Executive. To say that we could claw back that authority via fortnightly meetings, when some policies receive the attention of Committees for 20 minutes or half an hour, is a parody of policy development. We should be honest and say that we do not do it in that way. We must concentrate on major investigations, as they involve genuine policy development."

He also recommended that policy work on executive policy development be included within the time spent on the Minister's monthly report to the Committee:

"Allocating more time, perhaps up to an hour for the monthly report, would allow Subject Committees to consider more of the detail. It would also ease the burden of having numerous items on the agenda on which the Executive is working, and on which the Committee will not be able to spend the time necessary to give meaningful policy input."

There are already signs that the Committee is moving towards instigating longer-term policy reviews. In May 2001 a meeting of party spokespeople requested the Secretariat to prepare a paper on possible issues that could be considered in a review in October in the area of children's health. The paper recommended the Committee to consider action related to the health of school age children, children's tertiary services, and children with special educational needs and disabilities. In general the Committee reached a consensus that the health of school age children and special educational needs should be the focus of a policy

review in the autumn. And it recommended that any review should fill a gap in research currently undertaken elsewhere.

One issue in particular demonstrated the new power of the legislature in coalition government. This was the extent of eligibility of free eye tests. The Committee from the start had a majority in favour of extending this concession far beyond the groups previously eligible under UK rules (principally the elderly). Despite the increased cost, and advice from the Chief Medical Officer for Wales that there would be no significant health gain, in late 1999 pressure from Plaid Cymru in particular, and subsequent recommendations from the Committee, resulted in the administration's agreement to extend the concession. Though the administration rejected the suggestion that free eye care should be available to all over 40, they set up an expert group to consider the issue. The group recommended a programme of free care aimed at detecting disease among specific at risk groups. The administration accepted this advice, and in 2001 announced concessions for people with one eye, with hearing impairments, suffering from certain hereditary diseases, or referred by GPs to optometrists.

**Scotland** - The Scottish Executive Health Department was one of six main departments in the new Executive. Its first Minister, Susan Deacon, was a former business consultant. The department's Management Executive was headed by a senior civil servant. The department was restructured in August 2000, after the departure of the Chief Executive, who had held the post for 8 years. The new post-holder, like his predecessor, had been a senior NHS manager - chief executive of Lothian since 1995.

Following the publication of a health white paper in December 2000 (*Our National Health - A Plan for Action, a Plan for Change*), reorganisation of the Scottish NHS took a direction opposite to that in Wales. The Scottish plan brought together the NHS Boards, Acute Hospital Trusts and Primary Care Trusts into 15 unified Boards, although Trusts were not abolished as legal entities, at least at this stage. These changes were to reduce the number of ministerial appointees by one-third, or some 100 posts. The Boards went live on 1 October 2001. Responsible for improving health and health services in their areas, the Boards were - according to the Scottish Health Minister - to reduce bureaucracy, improve decision-making, increase accountability and foster greater integration and partnership working. Local decision-making was to become "truly accountable to local people... [T]he views of staff and patients ...[would]...become a key part in local planning and decision-making." (Grampian Board press release 26.11.01) Local authority representatives were to play a much larger part, though the means for doing so were not specified.

In December 2001 the Minister announced a new 18-month review of management and decision-making structures. A press story [*Scotland on Sunday*, 30 December 2001] suggested that the underlying intention was to abolish all [28] NHS Trusts in Scotland and to centralise control under Boards and Ministers. The First Minister was reported to have denied this. [*Scotsman*, 31 December] (This was, however, to be the outcome: a White Paper in 2003 required all Boards to bring forward plans to dissolve their Trusts.)

The plan also pledged to strengthen the patient's voice: £14 million was to be invested over 3 years to improve communication, patient information and partnership working. The

theme was "clear local accountability from a streamlined NHS when things go wrong". The change programme was also to include a new accountability review process, while a complementary change programme would enhance public and patient involvement in the NHS.

The Minister urged the Boards to help change culture and practice throughout the NHS, to improve communication, reduce waiting and delays and ensure that services took full account of patients' needs. In December the Health Minister announced plans to give patients a stronger voice in the NHS. The "Patient Focus and Public Involvement Strategy" would give patients more say in service design, and there would also be an independent complaints procedure. A new "NHS Scotland Forum" was to bring together various groups, including patients and community bodies, to identify possibilities for improvements in services. There would also be consultations about a new Scottish Health Council, responsible for assessing how well patients' views are heard and acted on. There were suggestions of more radical changes: a press report in August 2001 claimed that, as the Scottish Labour party started to draw up its policies for the 2003 election, ministers had prepared a policy paper asking whether health boards should be made more accountable - perhaps directly elected, or more closely linked to local authorities.

At the end of 2001 Scotland lost its second First Minister since devolution, when Henry McLeish resigned in the wake of a modest scandal. He was replaced by Jack McConnell. More directly important, for this report, in the ensuing Cabinet reshuffle the relatively long-serving health and community care minister, Susan Deacon, also resigned and was replaced by Malcolm Chisholm. Continuity was the theme emphasised by the new First Minister: the new cabinet was instructed to focus on current priorities in their portfolios, and on the delivery of existing commitments.

In August 2002 Malcolm Chisholm approved a plan to rationalise Glasgow's hospitals. A £700 million investment increased and improved some existing capacity, but also meant completely closing one hospital and closing the accident and emergency unit at another. Some administration members publicly protested against these plans, while a prominent campaigner announced her intention of challenging them by running as an independent against the sitting MSP in the 2003 Scottish elections.

In the Scottish Parliament there were five major debates on health issues in the first session. In the first six months of 2000 1100 parliamentary questions were asked in the Assembly on health and related matters - compared with a typical annual total, pre-devolution, of 1500 questions in a year to the Scottish Secretary of State in the House of Commons on all subjects. The Health and Community Care Committee, which has 11 members from all the main parties in the Parliament, has carried out enquiries into, for example, Hepatitis C; in its report (October 2001) the Committee expressed itself "very disappointed" at the Executive's refusal to compensate all hepatitis sufferers infected through the NHS. (Our Scottish partner has commented that even the compromise deal offered by the Executive could not be delivered without inter-governmental agreement on benefits.)

Unlike its Welsh equivalent, the Committee has from the beginning scrutinised the affairs of individual NHS Trusts (as indeed has the Assembly's Audit Committee, which in July

2001 produced a highly critical report about financial management in Tayside organisations). The Committee has also had issues remitted to it by the Petitions Committee - the future of a hospital and proposals to develop a unit for the treatment of mentally disordered offenders.

On the legislative front the Committee has, among others, considered the Community Care and Health (Scotland) Bill (whose principles it broadly endorsed but with some reservations on points of details) and the Tobacco Advertising and Promotions (Scotland) Bill.

In Scotland there is, as well as the specialist Committees, the unique Petitions Committee; citizens can submit matters of concern to them directly to this committee, which if it thinks fit can refer them on to the relevant specialist committee.

Scotland saw the single major example to date of marked divergence between London and a devolved administration on a significant policy issue. This was the Executives decision, in December 2000, to accept the recommendations of an independent committee (Sutherland) and to fund free personal care for the elderly. The full implications of this decision are discussed below, but it is perhaps worth noting here that some observers attribute the adoption of this policy as much to the influence of different personalities, agendas and internal politics within the Scottish Labour Party as to any fundamental differences between the UK and Scottish governments.

*Northern Ireland* - A contemporary account of the NHS noted that "Reform of administrative and management arrangements in Northern Ireland has proceeded at a much slower pace than the rest of the UK." (Baggott, R., 'Health and health care in Britain', Macmillan, 1998).

Our monitoring partners attribute the difficulty faced by the Executive in Belfast in part to the general absence of preparedness of all ministers after the long decades of 'opposition' under direct rule. In their view, there is in Northern Ireland a greater gulf than elsewhere between public discourse about health in the region and the requirements of an informed debate. This translates into what a former public-health official has called a 'policy deficit' on the part of the political parties.

Another source of problems has been the unique system of executive formation through which ministries were allocated. The parties were enabled to choose the Departmental portfolio they wanted according to the number of seats they had in the Assembly. The bigger parties therefore had a degree of choice, and it was interesting that they all avoided the Health portfolio, which may have been seen as a poisoned chalice, with many long-delayed decisions waiting to be tackled. Health was the second-last portfolio to be selected, agriculture being the last. The Health portfolio when it was chosen, was allocated to Sinn Fein member, Bairbre de Brun. In the Belfast Assembly the Committee on Health, Public Services and Public Safety was nominated in December 1999, with 11 members, from 5 different parties, 6 of whom were women.

In practice, any hopes of continuity in the policy process have been greatly weakened by the repeated suspension of the executive and the resumption of direct rule.

Ms de Brun has instigated a number of major consultation exercises, welcomed by her supporters but resulting in complaints from opposition members about her failure actually to take any decisions. In March 2001 she published *Priorities for Action 2001/2002*, the Northern Ireland initiative closest to the English "national plan" for the NHS, although this carefully eschewed any UK-wide references. It is part of the Minister's political agenda at all times to stress links with the Republic in the South rather than look to the rest of the UK.

One difficulty not of the minister's making is that a key player is obviously the Department for Social Development, with its responsibilities for the voluntary sector. But the department is in the hands of the DUP, whose two ministerial positions are periodically rotated. More importantly, the incumbents refuse to attend Executive Committee meetings.

In November 2000, shortly before Ms de Brun published her consultation paper on public health, the then minister for Social Development, Maurice Morrow, indicated he had no intention of discussing co-operation on the issue with his colleague at health. This was, however, only the tip of a wider iceberg of mistrust: as one senior minister is reported to have put it, 'Some of them can't stand the sight of each other.'

The Executive does not have any sub-committees. This has two important consequences. First, while there is a Ministerial Group on Public Health, a legacy of direct rule, chaired by the Minister, the absence of engagement by non-health ministers is an important barrier to the 'political buy-in' of other departments on which the success of the public health strategy depends. Secondly, the potential of the theoretically cross-departmental Executive Programme Funds is not being realised, because almost all bids for the funds have to date issued from single departments.

Any discussion of health policy in Northern Ireland has to recognise the extraordinary political context, which has led to a unique system of government which poses major obstacles for the policy and decision-making processes. Views on everything are polarised, and the climate of distrust leads any decision, or anything that looks like a decision, to be challenged by one faction or another. The rules under which the devolved administration operates make it relatively easy for opponents to delay or derail the decision making process.

An example of the way processes can be drawn out because of the nature of the decision-making process is given in our Monitoring Partners' description of Ms de Brun's first major decision, during her initial ten-week tenure, before the first resumption of direct rule. This concerned which of two rival maternity units should survive in the course of rationalising provision. Opinions were sharply divided, largely along constituency and sectarian lines, between two units. When, in January 2000, Ms de Brun made her decision it was apparently without either consulting other ministers or addressing the Health, Social Services and Public Safety Committee. She decided in favour of the Royal hospital which housed the regional paediatric service, the alternative City hospital possessing no paediatric service. When the Health, Social Services and Public Safety Committee debated the issue, it split largely on party lines and opponents demanded a judicial review.

In November 2000 the high court upheld a challenge to the Minister's decision to close the unit in the City hospital. In response, in January 2001, she launched a consultation

exercise about a new hospital. This did not prevent the tabling and subsequent passage by the Assembly of a hostile motion requiring her to give due weight to majority views (in both Health Committee and Assembly) in support of the unit.

The Minister also encountered difficulties with the Committee over proposals to abolish GP fund holding. The Committee was unhappy that her consultation paper failed to propose any alternative arrangements and consequently passed an amendment postponing the abolition for a year.

In common with the equivalent Committees of the Scottish Parliament and National Assembly for Wales, the Committee has struggled to play a full part in the policy making process, although it has taken a number of initiatives to assert its role. The Committee held its own enquiry into the Minister's consultative document on primary care. This was notable for holding several meetings in closed session, and for the commissioning of a study of the private care system by a group of consultants at the University of Ulster. In addressing several other health-related issues the Committee liaised with other Assembly committees with interests in these.

In February 2001 two motions were agreed by the Assembly calling on Ms de Brun to follow the Scots and to implement in full the recommendations of the Sutherland report, proposing free nursing and personal care for the elderly. The chair of the Health Committee made the point that Northern Ireland's unique integrated delivery system for health and social care provided "an ideal opportunity to ensure that nursing and social care should be regarded as a seamless continuum, all free at the point of delivery." Ms de Brun replied that free "personal" care would cost more than £25 million, for which her department would require additional resources. Though the executive originally planned to introduce free "nursing" care in April 2002, Ms de Brun announced in September 2001 that they had decided that even this would be impossible.

It should be noted that, despite the type of difficulties described above, the Investing for Health Strategy was eventually published in March 2002. The preface, which was signed by the First Minister and Deputy First Minister, committed all Government Departments to working together to deliver on a number of key targets in public health. Moreover, the lead for these targets was assigned to specific Departments.

**England** - In England there have also been changes at all levels. The post of permanent secretary, DoH, was merged with that of NHS chief executive in 2001. The holder is responsible for overseeing policy as well as management, for both the NHS and social services.

The NHS Plan of 2000 forecast major structural changes in the NHS and also a bewildering patchwork of arrangements aimed at creating a "patient-centred" service. Following this, the structural changes have included merging most of the 99 existing health authorities, devolving many of their responsibilities to Primary Care Trusts; what remain are 28 "strategic health authorities" (SHAs) with responsibilities devolved to them from the 8 NHS regional offices. The latter have been reduced to four, covering geographical areas different from those both of the Regional Development Agencies (RDAs) and of the Government Offices for the Regions (GORs). The SHAs' roles include "holding local health services to

account"; they are accountable directly to the Secretary of State in London. (Almost unbelievably, it was announced early in 2003 that the four regional offices were to be abolished in their turn, a mere nine months after they had been set up.)

The changes aimed at patient-centredness are more complex. In contrast with Wales, Community Health Councils are to be abolished (from September 2003); the 184 CHCs are to be replaced by "Patients Forums", one for every Primary Care Trust and NHS Trust. (In the event, funding difficulties meant that the 571 Patients Forums would not be fully operational until April 2004.) Patients will be represented on every trust board. Patients Forums will report to a new "Commission for Patient and Public Involvement in Health". There are also to be other local bodies, called Voice, which will correspond to SHAs. ('Involving patients and the public in health care : a discussion document', Department of Health, September 2001).

In April 2002 the government unexpectedly withdrew health from the purview of the Audit Commission; the responsibility was now to be given to a new, independent health care regulator/inspectorate, the Commission for Healthcare Audit and Inspection, which would also incorporate the work of the Commission for Health Improvement. The list of new bodies also includes Patient Advice and Liaison Services, to be set up in all PCTs and NHS trusts, and Overview and Scrutiny Committees, to be set up by local authorities.

At the same time, a major element of the new English approach is the proposal to give highly-performing hospitals more freedom within the NHS by allowing them to become 'Foundation trusts'. This proposal, which has aroused much controversy and opposition, is discussed in more detail below. Operating freedom, however, is to be constrained by further arrangements prescribed by law. Trusts are to have "members", comprising "people living in the local area" and patients, who will be entitled to elect representatives to the trust's board of governors. Local people will have an absolute majority on the board.

At regional level in England there is for the moment no settled or consistent pattern. The public health responsibilities previously vested in the NHS regional offices now rests formally with the GORs, to which groups of public health officials have been transferred. At the same time, some of the RDAs have started to take an interest in public health as a contributor to, and outcome of, effective economic development and regeneration strategies. A variety of mostly informal arrangements have been established to reflect this developing interest, which in a number of cases has been catalysed by the proactive work of senior NHS public health professionals. Regional Assemblies have been slower than the RDAs to establish themselves as significant players in relation to any policy fields, including health.

**London** - The one part of England where the situation is significantly different is London. A possible model, though it too is still far from fully developed, is on view<sup>f</sup> in the one region in which an assembly is established and operational - London, which now also has its own elected mayor (at present Ken Livingstone). Neither the mayor nor the assembly have any formal responsibility for health services, though the mayor was offered an entree into this area by being charged with a concern for Londoners' health. This responsibility

was highlighted by the appointment, as the Mayor's public health adviser, of the Director of Public Health in the then London Regional Office - covering the whole of London. The assembly was initially set up without a health committee.

One London body with a clear health focus is the London Health Commission (LHC). This was set up in 1999 - before the advent of the London Mayor and Assembly - with backing from several public and non-profit bodies, to complement the new all-London NHS region. The Commission has been described as a "semi-formal advocacy coalition". Its functions are advisory, not executive. It has 44 members, some directly involved in health services. It had devised a London health strategy even before the mayoral election of May 2000. Since then it has carried out health impact assessments of the mayor's (non-health) strategies. Today, although some observers are impressed by the quality of the Commission's work and by its potential as a major player, it cannot be said to be a particularly visible political force in the London health scene. An earlier Constitution Unit report noted that

"The LHC's natural tendency to accept subsidiarity and focus on that which can only be done at a London level, combined with the great mistrust of many boroughs for anything Greater London, means that its connection with much London health work is poor - some interviewees active in local public health work could not identify any impact."

On the executive side, a recent development in London has been what many observers feel is a step backward - the abolition of the London Region and its sub-division into 5 SHAs. Workforce issues of the NHS organisations in each SHA territory are handled by a separate Workforce Development Confederation (WDC). While each SHA relates to a group of London Boroughs, and thus a degree of co-terminosity has been retained, many people regret that there is no longer a single, strategic NHS organisation for London as a whole.

Many observers had expected that the new elected mayor of London, although having no direct responsibility for health services, would find it politically necessary or expedient from time to time to take a stance on contentious issues such as proposed hospital closures or the management of epidemics. In the event Mr Livingstone has been virtually silent on health service and indeed health issues - partly, perhaps, because the occasion has not presented itself in the London context, partly because he has been preoccupied with public and private debates over the future of London transport in general and the London Underground in particular.

Until recently the Assembly, too, had taken little public interest in health matters. However, in April 2002 a new Health Committee was set up, with a remit

"to examine and report from time to time on:

- the strategies, policies and actions of the Mayor and the Functional Bodies.
- Matters of importance to Greater London as they relate to the promotion of health in London."

(Greater London Assembly, Executive Director of Secretariat, Report to Health Committee, 11 June 2002).

The Health Committee and the mayor jointly launched a "scrutiny" on access to primary care. Hearings took place throughout the summer and early autumn of 2002.

### **3.3(b) Overview - executives and legislatures**

For those familiar with the modern British public policy process, the most striking change in Edinburgh, Cardiff and Belfast since devolution has been the extent to which the executives have had to share power with the legislatures. In Scotland and Wales in particular it has not been possible to reproduce the familiar sequence in which policy initiatives would be planned by ministers advised by civil servants and then approved by a (usually) pliant Parliament dominated by ministers' own parties. This is partly the consequence of coalition government; the Welsh decision to extend the categories of people eligible for free eye tests was an example of the consequences of needing to appease coalition partners. The contentious Scottish decision to fund free personal care for the elderly, though partly reflecting the personal view of the then-newly appointed First Minister, was also in part a concession to pressure from the SNP (and, at least as importantly, from the Lib-Dems, with a voice in the Cabinet). Excessive party fragmentation in the Belfast Assembly has given the Executive Committee considerable powers of initiative, but even here the Assembly has on occasion been able to reverse Executive proposals.

A number of commentators and people directly involved in the system believe that the new closeness of decision-making to the voters and institutions affected has made it harder even than before to implement any kind of coherent strategies for health. Ministers are closer to the electorate; civil servants are closer to ministers. There is thus a new immediacy and intensity to both sets of relationships and to political pressures, which are consequently harder to ignore. In Edinburgh, one prominent commentator told us that the Scottish executive had failed to take an overview, and ought to do so. A serving official expressed the opinion that, in London, Alan Milburn seemed to have a coherent set of ideas; if Scottish politicians had the same, they did not seem able to articulate them.

The executives in Cardiff and in Belfast have both incurred frequent criticism for excessive consultation and reluctance to take decisions that might be contentious.

This tendency has been exacerbated by the attitudes and activities of the legislatures. In Wales, observers saw the Assembly, at least initially, as having been extremely reluctant to take "hard" decisions. Our Welsh partner has commented

"if devolution has not made the NHS itself more accountable to patients and the general public, then it has made the Assembly more directly answerable to patients and the public, largely via television political programmes such as *The Dragon's Eye* and media focus on health policy. Individual Assembly Members are answerable to their constituents for decisions about the reorganisation or closure of health services in their local area. This makes strategic planning as to the future location of acute and district and community services across Wales difficult when no Assembly Member is going to support a proposal that threatens a facility in his or her constituency."

In Scotland, one well-placed participant/observer expressed the opinion that the Parliament still "seems to believe in free lunches". Additionally, in Scotland, the existence of the Petitions Committee has enabled sectional interests to put items, such as hospital closures, directly on to the Parliaments agenda.

In Northern Ireland, similar attitudes were forecast by officials in a document produced for an internal meeting in January 1999: 'The primary motivation of Assembly members will be to seek advantages for their particular constituencies rather than advancing the interests of the region as a whole....Assembly members have up to now been in a "permanent opposition mode". They have not had to confront the hard decisions associated with priority-setting and resource allocation.' Our Northern Ireland partner has added that, if anything, this predilection for parish-pump politics is reinforced by successive social attitudes surveys that consistently give pride of place to health as the key intended beneficiary of increased public spending. Related to this is the absence of any debate about rationing. This is a legacy of the direct-rule political mindset when politicians could always demand X from the British government—for whom the spending numbers were puny in a UK context—without having to countenance a willingness to sacrifice Y. (See Northern Ireland final report March 2002)

Within the legislatures, the specialised committees have not won high reputations. At a recent workshop there seemed to be fairly general agreement with the statement that health committees had tended "to second guess local decisions, and to see themselves as an alternative to the Executive rather than its parliamentary scrutinisers". A senior Scottish politician felt that in the Scottish Parliament the Committees had in general not been a great success - "ignorant, anti-authority, headline-seeking, their reports largely ignored."

### **3.3(c) Joined up government**

One sign of a new approach to governance would be a greater ability to think, plan and act across service boundaries. A quarter of a century ago the permanent secretary at the then Department of Health and Social Security noted that many "health" problems could never be solved by "health services" on their own, and could have been solved or at least alleviated by different or more effective action by employment, housing, education or environmental sendees. (Personal information, WP).

The original report which gave rise to this study suggested that

"health gain policies, which require coordinated action among departments, [may be] easier to operationalise in Scotland and Wales, as the smaller size of the administration and the ease of communication makes it easier to overcome 'functional chimneys' and to work across departmental boundaries."

In making this assumption, we did not recognise the need to distinguish between 'joining up' in the policy process and 'joining up' in terms of service deliver)', a differentiation we now see as significant.

Joining up at the policy-making stage can and should be distinguished from joining up of service delivery. Further, we now recognise that we must try to distinguish between scale

differences and *cultural* differences. The former has brought some differences, for example in access to policy makers and the policy process, and inclusiveness. But without changes in the latter, for example in the mindsets of politicians and administrators, scale changes alone will not deliver joined-up government.

One of us has written elsewhere that "joining up" in government is an unnatural activity. It cuts across all the imperatives and priorities naturally dictated by established organisational structures and incentives. (Klein, R and Plowden, W., 'Background paper for Nuffield Trust seminar on Joined Up Government', February 2000). Politicians and bureaucrats, responsible for programme X, rarely see much benefit to be gained from activities that will help other politicians and bureaucrats to make a success of programme Y. Moreover, the test of effective joining up is its impact on outcomes; and this raises problems of timescales. Even in the limited timescales within which politicians and officials work - the five years of a parliament normally being the maximum - it is possible to see results in terms of inputs: a hospital built, a health service reorganised. Results in terms of outcomes - an increase in life expectancy, a decrease in morbidity - are usually so remote as to be irrelevant. The same is true for the public as a whole. This is one reason for the collective obsession with health services, and the reluctance to focus on health status.

In fact health services are only one among many contributors to improvements in health status - and often not the most important. The most convincing sign of a new commitment to "joined-up government" in the field of health would be a new emphasis on the contribution to be made by other, non-health, services to improvements in health status - in other words, a new priority for public health rather than for health services and the NHS. In rhetorical terms, at least, such an emphasis is starting to emerge in Scotland and in Wales, where the parliament and the assembly have begun to address their populations' poor health status.

As for practice, some observers believe that devolution has encouraged or enabled more effective joint working, at least at the level of service delivery. Anecdotal evidence from work with public managers - it would be too strong to call this 'research' evidence - indicates that they achieve a measure of joining up on the front line of service delivery almost in spite of the system - i.e. they do just enough to keep the 'centre' happy and off their backs, and then they get on with what 'really' matters. However, to the extent that, in the policy village, everyone is closer to, and more visible from, the centre, this traditional 'public entrepreneurship' may become harder.

On the other hand our discussions with health professionals in Scotland and Wales over the past three years suggest that devolution may have made "joining up" at the policy level more, not less, difficult. There are several possible reasons for this. The first is the new dominance, in the devolved administrations, of politics and politicians, with their own constituencies and policy agendas. Secondly, under the pre-devolution arrangements the composite departments for Scotland, Wales and Northern Ireland brought a range of services, including health, under the control of a single secretary of state. Now each service has its own minister, with his or her own agenda, sometimes compounded by inter-party rivalries within a coalition government. In addition, the sectoral committees of the legislatures have insisted on playing a part in both the governance and the accountability

processes for the services which they monitor. In so doing they have emphasised and reinforced the "functional chimneys" on the executive side.

In Wales, one observer of the processes of reviewing Professor Townsend's proposals for resource reallocation to tackle inequalities in health commented that the Assembly showed little sign of joint working. When the several committees responsible for health and social care, and economic development, came to review the proposals, there seemed to be little communication between them.

In Northern Ireland, if "joined up government" has in general been elusive due to the familiar intrinsic difficulty of managing across boundaries, our monitoring partners comment that it has been made far more difficult by political rivalries, and in particular by the mutual hostility between the DUP and Sinn Fein. They cite as an example public health, where Ms de Brun declared the need for "the combined exertions of all Government Departments" (October 2000). But the DUP Minister for Social Development refused to meet her to discuss public health issues. As mentioned above, however, by March 2002 the Investing in Health Strategy did commit all Government Departments to working together to deliver on key targets.

In the English regions, our discussions have revealed signs of some internal interest in greater collaboration between regional institutions and public health officials, but no results of this are yet perceptible.

Survey findings, which we introduce below, throw a little oblique light on this area. All three countries report that "joined-up government is as elusive as ever", while simultaneously agreeing that "inter-organisational working is now easier". What do these apparently contradictory findings mean? One plausible hypothesis would be that, on the one hand, it is as hard as ever to change professional behaviour on the ground; but that the movement of political control to Cardiff, Edinburgh and Belfast makes it easier for heads of organisations to communicate - or, possibly that constraints on communication have been lessened with the disappearance of the UK territorial Secretaries of State.

#### **3.4. The experience of devolution - the views of health professionals**

Two surveys conducted during a related project provide an additional perspective on some of the changes within the family of UK health services that have resulted, or are resulting, from political devolution. We surveyed a wide range of people working in different parts of the NHS - board members, managers, physicians, nurses and others. We asked them about changes brought about by devolution in a variety of contexts - for example, changes in the extent of their contacts with other groups, such as politicians, civil servants, NHS professionals. We sought their views on changes in the influence of the same groups on matters of policy and organisation; in their own involvement in UK-wide professional bodies, and in the relevance and value of such involvement. We also asked them to agree or disagree with a range of specific statements about the effects of devolution (for example, *Decisions are made more quickly; 'Joined-up government' is as elusive as ever; There is little scope for strategic planning and thinking; Managers are freer to manage*).

Trends indicated by the surveys fall into three main categories:

- The changing patterns of contact and influence among the different stakeholders
- The relative priority afforded to issues of scrutiny/accountability compared to that given to strategic leadership
- The impact or otherwise of devolution on the core values underpinning the health systems in the different countries.

We will discuss each of these in turn.

As might be expected, political devolution significantly affects patterns of contact and influence among the key players in health policy and management. Responses suggest that contacts between those in the health services and "home administration" ministers have increased substantially, and that the influence of the latter has grown more.

While there have been variations in the extent of contact with local/regional politicians, contacts with UK Westminster politicians are reported to remain as frequent as before devolution. This last finding is to be expected. It is not unnatural for Westminster MPs to be reluctant to be frozen out of issues concerning constituency services, and it is difficult to imagine them turning away a constituent with a problem.

In general, contact with UK civil servants has decreased, something noted rather more strongly in Wales and Northern Ireland than in Scotland. This may simply be a reflection of the way the administratively devolved arrangements operated pre devolution. Interviews suggest that "UK" departments were intensively involved in Welsh and Northern Irish policy-making before devolution (in Wales, because the Welsh Office had limited autonomy, and in Northern Ireland because of the Northern Ireland Civil Service's limited policy resources). The degree of Whitehall engagement with the Scottish Health Department may have been somewhat less. In sharp contrast, and to be expected, the influence of *home administration* civil servants is reported to have increased, particularly in Scotland and Wales.

The findings suggest that UK politicians, as well as devolved politicians, can exercise direct influence, by using the structures and networks inherited from before devolution. However, UK civil servants, previously the transmitters of the details of London's policies, appear to have receded in importance along with those policies themselves.

Print and broadcast media can exert significant influence on health policy formulation and the operation of the health services. The surveys suggest that the national and regional media in the devolved countries have, at least maintained and, in many people's eyes, increased their importance. At the same time, the all-UK media has retained its importance.

Taken together, these results indicate:

- the increased importance of devolved politicians;
- the stable continuing importance of opinion-forming UK politicians;
- the increased importance of devolved civil servants; and
- the declining importance of UK civil servants.

Turning to issues of accountability and leadership, the survey evidence suggests that the balance is yet to be struck between scrutiny and accountability and the strategic leadership of health improvement strategies. The information suggests that for the management of the health services the transition to political devolution has not been easy. Managers perceived themselves to be less "free to manage" than pre-devolution, and there is some support for the assertion that decisions are more influenced by short-term political considerations.

Four groups in particular report experiencing a greater degree of *democratic* accountability are Chairs, Chief Executives, Medical Directors, and Senior Managers. The role of senior managers is partly to manage the relationship between the health service professionals and their political masters. These groups felt that managers had significantly lost influence on health policy and organisation since devolution. It would be very interesting were it possible to compare these findings with the perceptions of similar groups in England, but no survey data for England is available.

The picture, in all three countries, is of a consistent, if small, decline in the visibility and influence of the UK ministers and MPs. Whitehall shows a marked decline in influence in all three countries. Further, the importance of the UK sphere seems to decline progressively from issues of contact (which the UK politicians can initiate); to influence on policy (where there are still many cross-country public comparisons, on funding issues in particular); to organisational design and management (where the UK political and media spheres have least influence). This suggests the UK arena focuses on public expectations while issues of organisation and management are more for the rather smaller policy communities based in the devolved countries.



## 4. HEALTH SERVICE REFORM IN ENGLAND: 'TRANSFORMATION' NOT 'CONSOLIDATION'

During the Project, there has not been an English monitoring exercise of quite the same sort as has been conducted in Northern Ireland, Scotland and Wales. Consequently, the Project's Annual Reports, and the information posted on the Devolution and Health website, has contained relatively little about developments in the English NHS. It has become increasingly apparent that, in terms of innovation and divergence, some of the most striking developments are happening in England. For these reasons, we devote rather more space in this report to an analysis of the way the English NHS has been developing. These changes have been driven by the Secretary of State for Health, and the Department of Health operating in its English role. None of the major developments can be attributed to devolution *within* England.

### 4.1 Innovation

One issue raised in the first report was about innovation. We suggested that, in large systems, innovation was often at the periphery and that in the devolved future the English NHS might have things to learn from experimentation/innovation in the devolved administrations (although we also noted the traditional English ignorance of/indifference to things that happen in Scotland, Wales and Northern Ireland).

In saying this, we may have played down too much the possible significance of innovation in the 'centre' and its consequences for the devolved administrations. In other words, what would be the implications for the health services in Scotland, Wales and Northern Ireland if the English NHS was to adopt a radically different approach to solving its problems, and one which - for whatever reason - did not 'fit' with the aspirations, values, or contexts in those countries?

In the past fifteen months, it has become increasingly obvious that there is a dimension to the agenda for the English NHS that is not necessarily replicated in the devolved administrations. It relates to the management and organisation of the NHS, and the principles underlying these. Here the language of the English NHS plan increasingly diverges from the rhetoric in Scotland and Wales.

In the first years of the post-devolution age a continuing feature was uncertainty as to whether public policies and pronouncements made in London applied to the whole of the UK or only to England. This uncertainty began with Ministers, who often seemed unsure whether their powers ran beyond the boundaries of England, but who also sometimes seemed to wish to imply that this was the case when, in fact, it was not. A Ministerial speech might veer from references to England and to the UK, with no explicit distinction between the two, from one paragraph to another. Uncertainty was magnified by the media, not accustomed to making or perceiving differences between England, Great Britain, the United Kingdom on the one hand and Scotland, Wales and Northern Ireland on the other, and compounded by near-universal indifference to these distinctions on the part of the general public.

In the case of health, the familiar usage of the "National Health Service" is now almost always misleading, given the undeniable fact that there are now in effect four national health services. Political rhetoric tends to deny this fact. It is extremely unusual for London Ministers to speak of anything else than "the NHS", and in doing so often to emphasise its truly national (sc.UK) character, based on nationally-shared values, as a crucial part of "the cement that holds the nation together".

This has been the case throughout the long process whereby the Secretary of State for Health, Alan Milburn, has tried to redefine the philosophy and the principles underlying the organisation and management of the English NHS. Mr Milburn has often implicitly extended this process to include the health services of Scotland, Wales and Northern Ireland. However, Ministers in the first two countries in particular have increasingly been at pains to distance themselves from developments in England. In terms of day-to-day practice, after some early attempts by the department in London to control things from the centre, there seems now to be little formal effort to resist divergence - even though Cardiff and Edinburgh have quite frequently felt that they have been 'bounced' by policy announcements emanating from London.

#### **4.2 Principles**

The significance of the Governments proposals for the English NHS, and in particular what these imply for the reform of public services more widely, has been the subject of much debate. The tone of the English proposals were foreshadowed in a speech by Alan Milburn in January 2002:

*"Our reforms are about redefining what we mean by the National Health Service. Changing it from a monolithic, centrally run, monopoly provider of services to a values-based system where different health care providers - in the public, private and voluntary sectors - provide*

*comprehensive services to NHS patients within a common ethos; care free at the point of delivery, based on patient need and their informed choice and not on ability to pay."*

*"Who provides the service becomes less important than the service that is provided. Within a framework of clear national standards, subject to common independent inspection, power will be devolved to locally run services so they have the freedom to innovate and improve care for NHS patients."*

Discussion of the structure and management of the English NHS was paralleled by a review of the financing of the NHS, UK-wide. The Wanless enquiry, set up by Gordon Brown, reviewed "the long-term trends and resource needs that will affect the health service [sic] in the UK over the next 20 years". Its recommendations, based on its assessments of need, were accepted by Gordon Brown, whose 2002 Budget provided for annual increases in NHS spending of 7.4 per cent over the next five years; by 2007-08, UK health spending was projected to reach 9.4 per cent of GDP.

### **4.3 Management and organisation**

On 18 April 2002 the Department of Health published the White Paper *Delivering the NHS Plan - next steps on investment; next steps on reform* (Cm 5503) describing the future plans for the English NHS. The purpose of this paper was to outline 'the changes needed to ensure the extra Budget investment delivers a world class health service.' The purpose of the plan was to achieve shorter waiting times, recruit more doctors, nurses and therapists, create more beds and to establish a better NHS pay system. But, for the purposes of this project, the most significant content was that which describes the organisational model on which the NHS needed to operate.

The Health secretary was quoted as saying "The 1948 model (of the NHS) is simply inadequate for today's needs. . . . We believe it is time to move beyond the 1940s monolithic top-down centralised NHS towards a devolved health service, offering wider choice and greater diversity bound together by common standards, tough inspection and NHS values."

While avoiding any mention of markets, the English plan was full of discussion of market-type mechanisms. Stronger incentives were to be introduced to ensure the extra cash produced improved performance. This was to include freeing Primary care trusts (PCTs) to purchase care from the most appropriate providers, public, private or voluntary<sup>1</sup>; and switching the hospital payment system to payment by results with the best hospitals receiving the most reward.

Incentive systems were to be used extensively in the English NHS. The White Paper accepted the Wanless Report proposals for legislation to make local authorities responsible for the costs of hospital bed blocking. It commented that "rather than imposing structural reorganisation or nationally ringfenced budgets, this scheme means that social services departments will be incentivised to use some of their large 6 per cent real annual increases to stabilise the care home market and fund home care services for older people." The paper also proposed matching incentive changes on NHS hospitals to make them responsible for

the costs of emergency readmissions, so as to ensure patients were not discharged prematurely.

The proposals affected not just the numbers of health professionals, but indicated the need for "fundamental changes in job design and work organisation." These would require new contracts for GPs, consultants, nurses and other staff.

Patient choice was to be placed at the heart of the reforms, with patients being given information on alternative providers with the option of switching to hospitals that had shorter waits.

There was also a major commitment to use of the private sector, building on the compact with the private sector signed by the English Health Department a year earlier. As the English NHS capacity grows, private providers were to be used where they could genuinely supplement the capacity of the NHS and provide value for money. This would expand choice and promote diversity in supply, particularly for elective surgery. New PFI mechanisms, joint venture companies, and international providers would all be developed. The White Paper also foreshadowed the creation within the English NHS of 'NHS foundation hospitals', mentioned above and discussed further below.

Innovation was also planned concerning capital spending. Instead of allocating capital itself from Whitehall, the Department of Health was considering the establishment of an arms-length Bank, controlled by the NHS itself, which would invest capital from the Budget settlement for long term and innovative capacity growth and redesign. The issue of whether or not NHS borrowing in this way could or should be kept out of the Treasury's public sector borrowing figures has continued to be hotly contested.

The White Paper also made a number of proposals affecting the governance of health services. It stated that the Government was determined to ensure that additional funding was backed by independent oversight of how the resources were being used, to ensure they delivered the intended results. At a local level this was to be done by requiring PCTs to publish prospectuses, accounting to their local residents for their spending decisions, the range and quality of services, and explaining the increasing choices that patients were to have. At national level, in a move that came as a surprise to many, there was the proposal to remove from the Audit Commission the role of scrutiny of the NHS. Legislation was to be introduced to establish a new independent healthcare regulator/inspectorate covering both the NHS and the private sector.

The White Paper declared that one of the main functions of the new Strategic Health Authorities would be "to hold to account the local health service". The following chapter was called *Strengthening accountability*. Some of the arrangements proposed here were internal, others external: a new consolidated Commission for Healthcare Audit and Inspection; a new Chief Inspector of Healthcare, who would not be appointed by ministers and who would report directly to Parliament (an equivalent body was to be created for social services); the publication by Primary Care Trusts of annual "patients [sic] prospectus" so that "every household in the country will...know...how performance has improved"; a promise of an Overview and Scrutiny of local health services, to be led by local authorities. The proposed "foundation hospitals" were to be given "freedom to

develop their board and governance structures to ensure more effective involvement of patients, staff, the local community and other key stakeholders."

These proposals were described by the Secretary of State as reflecting a belief "in the traditional method of funding, but a completely new way of running the service." (quote in Department of Health Press Release, 18 April 2002).

Shortly after the Secretary of State for Health published the English plans, they were described by Professor Alain Enthoven of Stanford University as being more Thatcherite than the system they replaced. Enthoven was quoted in *The Times* of 8 May 2002 as saying that, instead of the "comparatively timid Thatcher/Enthoven" model, the new proposals were "a bold wide-open market". The new system was "a logical extension of the previous one."

Since the Government has always maintained a strong criticism of what it believes to be the inappropriate introduction by the Conservatives of market mechanisms, opinions such as those of Professor Enthoven are likely to be unwelcome. The response of a spokesperson from the Department of Health, cited by *The Times*, was that "The (Conservative Government's) internal market was all about using competition to somehow drive up standards despite the fact (that) there was no real access to information for patients, no way of inspecting and no national standards, all things we have put into place." He further said that "We are also intolerant of failure and do not want the free hand of the market to determine which hospitals should fail, we will intervene before that. What we are trying to do is to give patients choice in the system in a way which raises productivity."

However, this exchange was far from the end of the affair. A continuing controversy has surrounded the proposed use of the private sector in the provision of health care, and as this has progressed, the Government's concepts of the 'modernisation' that needs to accompany the increased funding of the English NHS have been made more explicit.

The House of Commons Health Committee in session 2001-2002 produced a report on the role of the private sector in the NHS (HC 308 May 2002). This raised a number of concerns about proposals for a greater role for private providers in delivering NHS services. The Government's response to this report (Cm 5567) provided a clear indication that the use of independent health care providers was not a temporary expedient to overcome capacity constraints, but was intended to become a permanent feature.

*"Working with providers from the independent sector and from overseas is not a temporary-measure. They will become a permanent feature of the new NHS landscape and will provide NHS services. Different health care providers will work to a common ethos, common standards and a common system of inspection. Wherever patients are treated they remain NHS patients because they get care according to NHS principles - treatment that is free and available according to need, not ability to pay. This is the modern definition of the NHS."*

Even more recently, in August 2002, the Secretary of State for Health wrote in *The Times* about the challenge of reforming public services. He described the challenge in stark terms.

*"Here there is a choice. On the one hand we could choose a strategy of consolidation - accepting the reforms made so far and relying on increased public expenditure to deliver an expanded service, hut one whose culture remains essentially unchanged. Or, as I believe we must, we could choose transformation, recognising that extra spending alone is insufficient to deliver improvement in public services. Reform needs to go further, using resources to deliver not just improved services but a different sort of service - one where users are in the driving seat."*

Mr. Milburn went on to cite examples of institutions created by centre-left governments in Europe which favoured greater community ownership over state ownership. He asserted confidently:

*"There is no automatic correlation between tax-funded health care and healthcare supply run purely by central government. Tax-funded healthcare can sit side by side with decentralisation, diversity and choice."*

Applying this philosophy to health, he suggested that:

*"In health, this means primary care trusts having control over budgets with explicit freedom to purchase care from the most appropriate provider — public, private or voluntary. It means using spare UK private sector capacity, bringing in overseas clinical teams and encouraging new healthcare providers into the NHS."*

An important part of these plans was to be the creation of "foundation hospitals". In an announcement in May 2002, the Department of Health said that England's best hospitals were to have the opportunity to become 'NHS foundation trusts' which would be free from 'direct management' by the Department of Health. Such trusts would be free to make 'independent decisions' on investment and staff pay and would also be entitled to keep proceeds from land sales to finance new patient services.

The Department stated that foundation trusts would be not-for-profit organisations and would represent a middle ground between the public and private sector. Their assets would be publicly owned and they were to be protected from private sector take-overs. They would also benefit from a system of payment by results, and would receive extra resources for taking on more patients. Mr Milburn spoke of foundation trusts as helping to create "a radically different health service that is true to its values but has changed its structures - and one which learns the lessons from what has worked elsewhere in Europe."

However he also stressed that NHS foundation trusts would operate according to NHS principles and continue to provide NHS patients with high quality care that is free and delivered according to need, not ability to pay.

The Treasury objected strongly to the proposal to allow foundation hospitals to borrow on the open market; the battle between Milburn and Brown was extensively reported throughout the summer, and broke out into the open at the Labour party conference in October 2002. The debate focussed on the financial independence proposed for foundation hospitals and their freedom from Treasury controls on borrowing, and on the possible danger of creating a "two-tier" health system. Within the government, the intervention of

the Prime Minister finally helped to win the argument for the principle of foundation hospitals, but only subject to tight restrictions on their freedom to borrow. However, in Parliament and the Labour party the debate intensified; beyond the end of the period covered by this report the former health minister Frank Dobson, in the debate on the Queens Speech, declared his opposition to the principle, as being certain to lead to a two-tier service. (Wintour, P. and Carvel, J., 'Rebels to rebuff Milburn's olive branch', Guardian, 9 January 2003.)

Mr. Milburn also attempted to neutralise objections to foundation hospitals on the constitutional grounds that they would be unaccountable. He announced new "stakeholder councils", on which local people would have an absolute majority. These councils, including representatives of patients and NHS staff, would have powers to appoint chairs and non-executive directors of hospital management boards, and to approve the appointments of chief executives. They would be given overall responsibility for holding management boards to account.



## **5. ENGLAND AND THE UK NHS: RESOURCES AND PRIORITIES**

There is one context in which there should be little uncertainty as to whether UK ministers are prescribing for the UK as a whole, or for England alone. This is finance, where the respective responsibilities for several major programmes, including health services, are quite clearly defined. (The UK Treasury provides the money, and the devolved administrations spend it as they think fit.) In practice, however, there is much scope for confusion here too. Two factors are at work. The first is the growing tendency in English programmes to tie the sums allocated to spending agencies by the Treasury ever more closely to detailed performance targets and specific commitments. The second is attempts to relate such allocations to centrally-agreed assessments of need, however defined.

"These resources", declared the Treasury's 2002 Spending Review, "will help deliver the key priorities set out in the Department of Health's new Public Service Agreement." These priorities were defined under the headings of two "objectives": improve service standards, and improve health and social care outcomes for everyone. This is where the first factor mentioned above comes into play - the provision of resources to spending departments only on condition that they sign up to achieving some very specific results. Beyond the two broad objectives were a total of 11 agreed performance targets for health, including a general target of improving value for money in health and in social services by at least 2 per cent a year. Other targets - whose timescales vary considerably - included, for example, reducing the maximum wait for an outpatient appointment to 3 months, for inpatient treatment to 6 months, by the end of 2005; guaranteeing access to a primary care professional within 24 hours, from 2004; reducing mortality rates from heart disease by at least 40 per cent in people under 75 by 2010; reducing suicide rates; and so on.)

Most of these targets are expressed quantitatively, and their achievement can thus be monitored. One or two are not and are, in practice, virtually un-monitorable: ensure that hospital appointments are "booked for the convenience of the patient", "enhance

accountability to patients and the public..." Some will depend largely on actions by other public and private services and by citizens themselves (e.g. reducing suicides and heart disease mortality rates).

The constant UK governmental rhetoric of "the National Health Service" can easily lead the casual reader to believe that these are targets for all parts of the UK. Many of them clearly are broadly acceptable in all four countries, whether in the spirit or the letter. But neither Wanless nor the DoH chapter in the spending review make it clear that the new Public Service Agreement has no binding force beyond the Tweed, Offa's Dyke or the Irish Sea. Indeed, more basically still, even if the Treasury provides the appropriate levels of money there can be no guarantee that health spending in the United Kingdom as a whole will reach, or be limited to, any particular level. The reasons are, of course, that in the first place whatever may be attempted in England the devolved administrations receive their financial allocations as block grants relating to their total expenditure, not tied to individual programmes; it will be up to them whether or not any increments are spent on health services or on something else. Secondly, a fortiori, within the health budget their priorities are for them to decide. Their priorities may well differ from those of the DoH.

The reasons for such differences may be as much political as clinical. A further factor influencing divergence may be the "Barnett squeeze": if available resources are increasing more slowly in the devolved administrations, in the short run at least they may want to make different decisions about how the increment is applied. The general issue is acknowledged in the separate chapter in the spending review that deals, in general terms, with the devolved administrations: "Decisions on the use of [the] extra provision will be made by the [three] administrations...in line with the needs and priorities of the people of [the] three countries." This issue was not, however, acknowledged by the Wanless report, which appeared to assume that priorities were in some way objectively determined by need, as determined by what it called "patterns of morbidity and exposure to risk factors".

For the time being, however, there are strong political pressures for conformity. As long as Labour is in power in Westminster as well as in the devolved administrations, and as long as Gordon Brown remains at the Treasury, freedom to vary patterns of expenditure seems likely to remain nominal. As a Scottish ex-MSP put it succinctly

*"If Gordon Brown gives you money for health, you'd better spend a like sum on health. The wishes of the people of Scotland are no different from the wishes of the people of England."*

The position has been the same in Wales. As our Welsh partner has observed

*"It was... interesting to note that Edwina Hart, the Assembly Minister for Finance, found it necessary to follow England's example to the letter by committing Wales's share of a windfall of almost £50 million announced in February 2002 to an expansion on spending on health services. This money was not ringfenced and could have been arguably spent by other government departments either to boost the Welsh economy directly or to improve health through housing, transport or environmental initiatives."*

Shared values and common wishes notwithstanding, the different approaches among the three main countries are exemplified by the contrasts between the current objectives of

their several health services. The NHS in Wales is currently operating within a bewildering framework of over 40 "commitments" and 15 targets, set out in the National Assembly document *Plan for Wales 2001*. Some of these are quantitative, and have quantities attached ("Increase the number of doctors in training by 65%.") Others are quantitative in form but lack quantities ("Bring infant mortality-rates far closer to the best in Europe.") Some are qualitative ("Increase awareness of all languages and cultural issues in service delivery") Some are to be achieved by 2003/4, others by 2010. Whereas in England the Treasury has persuaded the DoH to sign up to some very specific quantified commitments in relation to waiting times, in Wales the more cautious commitment is "to reduce overall waiting times [by 2003/4], moving closer to levels that compare to the best". (There are, however, more specific targets for the priority areas of cardiac and cataract surgery and orthopaedics.)

The resources made available obviously provide the crucial context in which action to improve a nation's health is planned and taken. But for all countries, a further major question is how far the resources should be focussed on health services. The lists of performance targets tend to include some expressed in terms of health outcomes ("reduce mortality rates"), and others expressed as health service inputs ("reduce waiting times"). There is, of course, no necessary<sup>1</sup> or immediate correlation between the two. There may, indeed, be contradictions or at least implicit competition for resources. In either Scotland or Wales, countries whose health status is significantly worse than that in England and where the key importance of changing life-styles has long been recognised, it would be entirely reasonable for their administrations to decide that reductions in outpatient waiting-times were not a priority requiring a significant share of resources. The Welsh Assembly is grappling with this question in the aftermath of Professor Peter Townsend's review of resource allocation. This recommended what it called "a dual strategy - of measures to be taken within the NHS in Wales, and measures taken outside the NHS". The latter should comprise action within the competence of the Assembly, to improve community services, reduce deprivation and unemployment, and improve housing, environmental and other services.

The Scots are starting to witness the impact of the rather earlier Arbuthnott report, (Scottish Executive, Department of Health, *Fair Shares for All: Report of the Review of Resource Allocation for the NHS in Scotland* Edinburgh, 1999.) This raised the same issues in a Scottish context. However, it was focussed more narrowly than Townsend, on allocation "for the NHS in Scotland". It defined the principles which should underlie any method of distributing funds between the 15 Health Boards. These should include giving all Scots equal access to healthcare, taking account of deprivation and the needs of those living in remote and rural areas. The new formula reflected local population levels, age structure and gender balance, levels of deprivation and the proportion of the population living in remote and rural areas. Future increases in funding were announced in April 2001; whereas even' Health Board was to receive an increase of at least 6.5 per cent in 2002/03 and 7.4 per cent the following year, the four most deprived Boards were to receive 7.3 per cent and 8.2 per cent respectively.

To summarise the position, it is not so much the detail of the proposals that matters. The significance is that, in England, in health and in other areas of public services, the argument between what Alan Milburn terms 'consolidation' and transformation' appears to be moving in favour of the latter. At the heart of this debate are issues about the use of markets, or market-type mechanisms, to produce step changes in performance. In the current situation, the Chancellor can require his Ministerial colleagues in spending departments to produce plans for use of the additional resources, on the basis that there can be no new investment without results - i.e. reform and productivity improvements.

Neither the Chancellor, however, nor the Secretary of State for Health can be held accountable for changes in the levels of health spending in Scotland, Wales and Northern Ireland, let alone for the outcomes of any increases in these. They have no mechanisms for generating productivity improvements across the borders. As already described, practical politics may mean that English funding increases will drive similar increases in Scottish and Welsh health service funding (via the Barnett formula). But in these cases accountability for how the funds are used, and what results they produce, lies wholly within the Scottish and Welsh executives.

This is, of course, the same contrast as is found in relation to *public* accountability. In England there are to be two drivers of improved performance. The former is to be ever-more demanding Treasury conditionality, working through public service agreements. The second, as mentioned below, is to be patient choice, informed by published information and the presumably well-publicised activities of the oversight agencies. In Scotland, Wales and Northern Ireland, reliance will be on traditional democratic institutions: parliamentary scrutiny, patient representation (albeit sometimes at one remove, via local authority representation) and the ballot box.

## **6. THE UK - THE ROLE OF THE PROFESSIONS**

### **6.1 Introduction**

The original 1998 Devolution and Health report found that the Royal Colleges, and other similar, professional organizations valued their all-UK networks, and reported concerns that these might fragment under the stresses that devolution might bring. It suggested that the professional bodies would continue to seek to foster the flow of information and ideas across the UK's different health systems, and might therefore help provide 'the glue that holds the system together'.

The report noted that the professional bodies were likely to seek to maintain conformity in standards of clinical practice, education and training, and terms and conditions of service. Such bodies therefore would tend to be a force for policy stability and commonality. This might constrain any new developments which implied divergence between the four countries of the UK.

With this in mind, in preparing the first annual report of this Project, we asked the professional bodies and Royal Colleges how they were responding to devolution; we were interested, in particular, in changes in their governance structures and processes, in any challenges that they could identify in their continuing ability to influence health policy, in any other problems that they might face and in any changes that they might envisage in their working relationships with institutions of the European Union.

The responses which we received in late 1999, which were summarised in our first annual report, revealed wide variations between the different organisations. Some considered that they already had arrangements for governance and organisation which could cope with devolution without further change. Some had made substantial changes in their own structures since devolution, others were still reviewing the situation, others again did not envisage making any changes at all. Looking ahead, several foresaw the possibility of

fragmentation and divergence between the four countries of the UK, uncertainty about the several relationships between governments and health services, and problems for themselves in working closely and effectively with the key actors in all countries. Few had anything specific to say about their relationships with EU institutions.

## **6.2 Further changes in structures and processes**

Three years later, we asked a sample of the professions to tell us about subsequent developments. Several of them have continued to evolve, and to adapt both structures and processes to match the realities of devolution. They have also had to adapt to strengthen their role as professional regulators, to take account of government requirements. Public and governmental concern about the effectiveness of professional self-regulation came to head in the enquiry into the failings of children's heart surgery at the Bristol Royal Infirmary, an issue within the English NHS which nevertheless has had major implications throughout the UK. The Kennedy Report on that episode made important recommendations about self-regulation. These were broadly accepted by the government and enshrined in new arrangements: the regulatory bodies are henceforth to be accountable to a new UK Council of Health Regulators and, through it to Parliament. (Its director is appointed by the Secretary of State in London, in consultation with his colleagues in the devolved administrations.) However, even though professional regulation remains a UK function, responsibility for education and training, including continuing professional education and development, is devolved. Professional bodies therefore need to ensure that any changed arrangements are acceptable in the devolved administrations.

We have been told about the new arrangements that have been, or are being, made by a number of bodies. For example, the Royal Society of Medicine has set up a more extensive network of regional activities throughout the UK, with the appointment of thirteen regional "Sub-Deans". These represent roughly the former NHS regions; two of them are in Scotland, one in Northern Ireland (though covering the whole of Ireland), one in Wales though leaving the north of Wales to be covered by one of the Sub-Deans for the north-west of England. Their role is to set up a small committee and to organise about four meetings a year in their area; they are also members of a Regional Board, established in late 2001, which will meet four times a year in London.

The Royal College of Nursing (RCN) has considered proposals to change its geographical boundaries within England to make them coterminous with those of government offices, to establish new RCN Boards in each region and to revise and develop the constitutions of both regional Boards and of the pre-existing country Boards. There was widespread support for the principles of these changes; the new English regional Boards were in "shadow" form by late 2002 and due to go live in 2003. Members and staff of the English regions have begun to develop working relationships with their respective Regional Development Agencies and Regional Assemblies; most of the shadow boards have discussed the implications of further political devolution and the contents of the White Paper *Your Region, Your Choice*.

Meanwhile the RCN's existing Boards in Scotland, Wales and Northern Ireland have grown and developed so as to exploit the many new opportunities for influencing policy on behalf

of nurses. Thus additional parliamentary and policy staff have been appointed in all three countries. One new means of dealing with country-specific policy differences is "policy principle frameworks". These allow flexibility in dealing with such differences within a consistent UK-wide approach. (It is perhaps worth noting that, like other professions, Nursing, Midwifery and Health Visiting staff are still regulated at UK level.)

The pathologists have moved in much the same direction, though pointing out that they have done so only partly in response to devolution. They have established elected regional councils in eight English regions and similar Councils in Wales, Scotland and Northern Ireland. The new national Councils are accountable to the main College Council, of which their (elected) chairs are ex officio members, as well as of the College Executive.

The Royal College of Paediatrics and Child Health have now decided to set up separate offices in Scotland and in Wales, with premises and part-time secretarial support. (Their All Ireland Committee does not yet feel ready to have its own office and is working in conjunction with the Royal College of Physicians of Ireland.)

The working party set up in 1998 by the Royal College of General Practitioners reported to the Colleges Council after our earlier report had gone to press. Its work has now been concluded. The College has decided to establish a Northern Ireland Council, with powers equivalent to the existing Scottish and Welsh Councils (a change which has required amendments to the Colleges constitution).

A rather different approach has been taken by the speech and language therapists, who have changed the ways in which representatives are appointed to decision-making committees so as to ensure that these include members from the devolved administrations. Committee agendas have been restructured to as to ensure that country-specific issues can be raised. For Scotland, these arrangements have been underpinned by the appointment of a "Scottish officer" who lives in Edinburgh, who monitors developments in Scotland. The possible appointment of a paid officer in Wales is under consideration. Elsewhere, there are Regional Councillors.

The dentists, conscious of the General Dental Councils role as a UK-wide regulator of professionals many of whom work partly in the devolved administrations, have ensured that the Council's professional and lay members are drawn from all four countries. But they see an intensifying need for close liaison with government bodies and with politicians throughout the UK as the Council becomes more proactive in its regulatory role - looking at quality of care issues as distinct from matters of professional conduct. The consequence is that the Council, while remaining and acting as a UK body, has developed regular links with all four departments of health, and also engages with elected politicians in order to explain the Council's work and to seek comments.

The Royal College of Anaesthetists has made only one formal change in its structures. Having declined to be drawn into any "all-Ireland" arrangements, the College has now provided that the chairman of its Northern Ireland group should now be an ex officio member of the Colleges main Council.

### 6.3 Problems and challenges

What then, three years on from devolution, are the major problems and challenges as seen from the viewpoint of the various professional bodies? Comments from our interviews and correspondence present a rich picture of a complex and still evolving situation.

*"... [T]he diversity between the delivery of health services in the four countries of the UK continues to grow", commented one Royal College. The President of another College agreed: "the domestic NHS affairs of the three devolved countries... are drifting away from England (and there are many examples) ". Hence the view of a third profession that the main devolution-related problem is "the production of advice from a national body which is relevant and applicable to the healthcare systems' policy of the devolved nations". Closely linked to this is the challenge seen by a fourth College, of "finding people who are sufficiently knowledgeable to be able to respond to all the different consultation documents. It is difficult from London to keep track of all the different country initiatives." This is perhaps the reason for the view of another, that "domestic NHS affairs...are slipping out of the strategic vision of the main College and being managed more and more by our local representatives."*

The anaesthetists' Scottish Board has become better organised as its workload has increased, reflecting the constant need to make representations to the Scottish Parliament; the underlying aim here is to offset pressures to develop specifically Scottish approaches and to minimise divergence between Scottish and UK practice, given the difficulties that this could cause the profession.

However, not all agreed that the trend was towards divergence. One College noted that, despite increased diversity, a number of new regulatory and monitoring processes were being introduced which had a UK-wide application; the result was that some areas were tending to align again.

Perhaps the most realistic summary was that of the College just mentioned: that where devolution was concerned, there is no single clear-cut picture across all issues: *"it is a scenario that continues to change and develop almost constantly."* Change brings uncertainty - for example, as seen by the speech and language therapists, uncertainty about how regulation will be carried out in the long term, or how funding for education will be provided and, consequently, how far existing differences in the student experience would continue to increase.

Cuts in funding for professional education in the devolved countries could lead to changes in some courses such that these would fail to meet existing standards; this could fragment the professional bodies across the UK. Growing divergence of this kind could affect the ability of Colleges and other bodies to continue to set professional standards throughout the devolved countries. The alternative could, of course, be for the devolved countries to establish their own representative bodies.

#### 6.4 The professions' dilemma summarised

There is no doubt that devolution has brought challenges for the UK's professional bodies, some of which have been described above. In nearly every case, the result has been an increased workload, as the different bodies respond to the needs to relate to the devolved administrations as well as the UK centre. Especially for some of the smaller professional bodies, this increased burden has not been easy to resource.

In those areas where policy responsibility is devolved, the advent of devolution may have changed the balance of power by weakening the all-UK voice and its impact on policy. Where this has happened, it may have disproportionate effects on some of the smaller specialities. As one respondent commented "*As a member of a small speciality I am concerned that it is hard to provide the same quality of professional input to policy measures in Scotland as is available within the larger group of colleagues. Scottish policy making is less likely to have the benefit of expert advice and is in danger of missing big issues that are important to me.*"

The over-arching challenge to professional bodies in the UK is to find appropriate ways of addressing both *regulatory functions* and *professional interests and issues*. Since regulation of the health professions is a 'reserved power', regulation operates at an all UK level. But many other matters of major concern to their members will be determined by the devolved administrations (contracts, for example). If professional bodies are to maintain their positions as the UK regulatory authority, they will be required to adopt the governance structure, sizes and compositions of governing body, etc. that the Government requires. But they will also have to find ways of addressing the 'national' agendas and priorities to the satisfaction of their members.

There are thus two reasons for the need to reflect devolution in professional bodies' structures and ways of working. One, of course, is the need to represent views to the new centres of decision-making power in the devolved administrations. But there is a second, in that members in the devolved administrations are reported now to expect a more local 'service' from their professional body. The good news here is that, as a result of the post-devolution changes they have made, a number of professional bodies tell us that they believe their service to their members has improved, as an indirect result of addressing the 'political' consequences of devolution.

Looking to the future, given the changes resulting from devolution, it seems likely that there will be greater diversity in terms *or professional interests and issues*. The key here is to allow continued exchange of knowledge, experience and best practice across the profession in Great Britain, while allowing greater diversity of activity within each Country.

Small scale surveys, carried out by the Constitution Unit, of members occupying key representative roles in professional bodies suggest that in general the institutions have managed to maintain their UK-wide networks. These networks tend to be focused on medical/clinical issues rather than matters of policy or organisation. But at the same time most professional organisations appreciate the increased opportunity of being able to influence 'national' policy with the "repatriation" of much health policymaking. While this is generally considered as a positive outcome of devolution, a more negative outcome is the

suggestion that devolution has, if anything, further reduced the autonomy of the professions and of professionals. That is, in the devolved administrations, the influence of clinicians and professional organisations is reported to have decreased, as that of devolved administration politicians and their civil servants has increased. However, not everyone sees things this way. One Scottish professional commented *"As a professional I am more involved in the process of health policy formulation and delivery and I believe that my voice is more likely to be heard."* This is a minority view however.

At a time when, in most parts of the health services, there continues to be rapid organisational and policy change, the professional bodies are proving to be resilient and adaptive organisations. Their importance to their members, if anything, increases as the rate of change in the health services increases. Their ability to span the UK and 'national' agendas is likely to be tested increasingly as the devolved health systems emerge further. A positive feature is that the survey results suggest that the professional colleges are seen as either retaining the same influence as before devolution or slightly increasing it.

The major stress may come more from the 'trades union' aspect of professional bodies' roles rather than from the regulatory roles. One of the most striking examples of 'national' differences emerging within professional bodies was over the UK government's proposed new consultants' contract framework, agreed with the BMA following lengthy negotiations. The proposals were rejected by consultants in England and Wales, but approved by the Scottish and Northern Ireland consultants, who subsequently decided to begin local negotiations. Also, the Scottish Committee for Health and Medical Services has decided to negotiate changes to the distinction award scheme in Scotland, and will need to put in place arrangements for disciplinary processes different from those in England.

## 7. THE EUROPEAN ISSUE

### 7.1 Introduction

The First Report commented that a particular concern of many in the devolved administrations was how relationships with Europe would be handled post-devolution. This concern was based partly on previous experience of the Department of Health's handling of 'international' issues. It was claimed by representatives of the Scottish and Welsh administrations that traditionally the Department's International Branch had neither communicated well with, nor sought to involve, them. However, since devolution, these concerns seem to have been somewhat allayed.

Major tensions over 'international' health politics appear to have been avoided so far. The Department of Health, in its UK role, appears to have worked reasonably well to involve the devolved administrations in EU affairs. UK delegations have, on occasion, included health ministers and/or civil servants from Scotland and Wales, and there seem to have been no major difficulties caused by the operation of the policy machinery relating to Brussels.

The influence of the European Union in health policy has increased rapidly in the past three years and this process seems likely to accelerate. This may well pose greater challenges for the UK policy machinery, and for inter-governmental relations."<sup>1</sup>

The European Commission recently has been investigating health policy. The Commission points out that, although the current perception is that health systems are entirely Member States' areas of responsibility in fact a wide range of Community-level legislation impacts on them. The Kohll and Decker rulings of the European Court of Justice in 1998, and the Smits-Peerbooms rulings of July 2001, stress that Member States' health systems, and in particular the delivery of health care, do not lie outside the jurisdiction of Community law.

The English Department of Health had occasion to realize this in 2002. The effect of a

4. See Elias Mossialos, Martin McKee, Willy Palm, Beatrix Karl, Franz Marhold, "EU Law and the Social Character of Health Care", 259 pp, Peter Lang Pub, 1 September, 2002, ISBN: 0820446912

ruling in the European Courts was to give patients, forced by their national governments to endure lengthy waiting times for treatment, the right to receive treatment abroad at their government's expense. The English Department of Health's initial response was that the ruling would not lead to any policy change. This position was rapidly abandoned. Within a matter of days the Secretary of State for Health was announcing a change of policy, permitting long-waiting patients to be treated abroad.

This episode demonstrated clearly the influence of European legislation on the UK NHS, but the legislation concerned was neither in the field of health nor health services. As such, its impact on health essentially was incidental. Steps have now begun to be taken to rationalise this state of affairs.

## **7.2 Working Group on the Internal Market and Health**

The European Commission comments that, at present, the impacts of the various areas of EU legislation on health policy are inherently unsystematic. Accordingly, the Commission has begun exploring the impact of EU legislation on health systems, to understand whether a more proactive response is required at European level, and if so how this might be achieved in a way that would be acceptable to Member States. The Commission's High Level Committee on Health set up a Working Group on the Internal Market and Health to:

- Collect information on the impact of Community provisions (Treaty and secondary legislation) on health systems, in particular access, flow of services, reimbursement mechanisms, financing of services and setting of overall health budget, quality of services, manpower planning, education and training of professionals
- Collect information on cross-border health care and service arrangements
- Identify the nature and degree of problems arising and consider options for Community and national actions to resolve them

The Working Group's report (European Commission, Health & Consumer Protection Directorate-General, "The Internal Market And Health Services", Report Of The High Level Committee On Health, 17/12/2001) notes that Member States acknowledge that the Community has an important role in health. But, since health care systems are an essential part in national economies, accounting for between 5% and 10% of GDP, some Member States argue that the scope of health policy at EU level as it affects health care should be fairly narrowly defined. In particular, these States oppose the idea that health policy at EU level should cover matters concerning health care systems and health services, citing the principle of subsidiarity among other reasons.

Over the past few years health policy has been rising in prominence on the Community's policy agenda. The Treaty provisions in this area have been widened, and there is now a Commissioner responsible for health and consumer policy together with a corresponding Directorate-General, although there are also other Commission services dealing with health-related matters. Yet health policy at EU level is still in its infancy and, in the Working Group's view, it has not yet been given the priority it requires in policy-making within EU institutions.

The report concludes that a priority for the immediate future should be development of a proactive and broader health policy under which the main health interests will be addressed and co-ordinated. Unless this happens, Community measures which impinge on health will continue to be largely influenced and dominated by economic considerations and factors, and not by health policy interests.

The Working Group suggests that, when preparing single market interventions, the Community has tended to neglect intended or possible unintended effects on the different health care systems. Partly because health ministries have not tended to interest themselves greatly in these areas, more and more issues have been decided by the European Court of Justice. Consequently, the Court is put in the position not only of interpreting the Treaty but de facto of making health policy by defining the influence of EU regulations on health care. The Working Group argues that this is unsatisfactory, and it would be better for health care issues to be addressed explicitly, rather than in this indirect way.

The report suggests that the starting point for further actions and discussions should be to acknowledge that EU Internal Market regulations designed to ensure the free movement of persons, goods, services and capital within the Community, apply to and impact on health care services. Therefore it becomes essential, inter alia:

- to raise the profile of health policy at EU level
- to bring key policy areas hitherto regulated in an internal market context into a health policy framework, including healthcare issues

It argues that there is a need for a clearer understanding of the principles underpinning Member States responsibilities. It suggests that these might include, for example, full responsibility for:

- How their health care system is funded (e.g. tax based or insurance based)
- What package of care is to be publicly funded
- The total level of public expenditure on health care and how it is allocated (e.g. centrally, Regionally etc)
- How demand is managed to keep within planned resources

Further, it asserts that Internal Market rules should be designed to take full account of the interests of patients and health services, not just economic interests.

The Working Group concluded that a process of discussion at Member State and EU level on these issues should be set in motion. It argued that there was some urgency for this, due inter alia to key developments such as the discussions on Treaty reforms and further cases pending in the European Court of Justice.

In addressing all these concerns, the Working Group believed there might well be a need to consider a reformulation of the EU competence in health, with the objective of moving all related health powers into one Treaty Article as a means of further clarifying roles and responsibilities.

### 7.3 Key policy questions for the future

Debates such as those in Europe reported above coincide with the higher profile that the UK media are giving to stories about the impact of European legislation on access to health care and of the differential performance of European health care systems. These developments point clearly to the inescapable conclusion that in future the European dimension is going to figure much larger in the formulation of health policies within the UK.

In the context of the Devolution and Health Project, it appears therefore as if the UK is going to have to engage more actively in discussing European health policy in the near future. This immediately raises a number of key policy questions, for the UK and the devolved administrations. Will these developments put new stresses on the policy process?

We might ask:

- If devolution has begun to allow national identities, cultures, values, to be expressed in the delivery of health policies (and health service policies), will this continue?
- Will European policy force more similarity, for instance in funding levels or mechanisms, individuals' rights to treatment, the 'rationing' of expensive treatments, and so forth? If so, what does that mean for the 'UK centre' and the devolved administrations?
- Will there be a need to 'rebuild' the UK Health Department to address these developments? It would be ironic if, just as devolution was seen to be allowing the different countries within the UK to address their health needs in different ways, developments in Europe served to re-impose a straightjacket on policy diversity.

Given the importance developments will have for the operation of inter-governmental relations, we might also ask whether IGR in health will become more fraught. We might further inquire about the implications of the lack of transparency and accountability of some of the IGR processes, discussed above, for the development of health policies by the devolved administrations.

## 8. CONCLUSIONS

### 8.1 Accountability & outcomes

There has been much rhetoric in the devolved administrations, especially Scotland and Wales, about enhancing local accountability to communities, patients, and citizens. With some exceptions, such as the preserved Welsh CHCs, most of the arrangements are not yet in place or have not had time to prove themselves. It is at the parliamentary level that change has been most marked, and has had most impact.

It has been commented that "political devolution has enabled a degree of scrutiny of health policy and the NHS that simply did not exist before" (Woods, K., Scottish Monitoring Report, March 2002). This should perhaps be qualified by adding the word "legislative"; the sheer volume of "scrutiny", through the range of new institutions proposed, could well be even greater in England. The point about devolution is that health providers are now subject not only to closer scrutiny, but also to greatly enhanced legislative accountability. Given that none of the three devolved administrations has a population larger than 5 million, the role and impact of their legislatures, and especially of the specialised health committees, could be qualitatively different from the position in England.

At one stroke devolution brought those directly accountable for health services many miles nearer to the citizens affected. If in practice the political salience of health means that ministers cannot resist the temptation to "micro-manage" in health matters, at least in the devolved administrations, where the lines of command are shorter, it is more realistic to hold them responsible for the outcomes (and they may indeed more clearly understand the situation on the ground). The quantity of "health business" transacted in each legislature has increased by orders of magnitude. Moreover, the position of health ministers in Scotland and Wales is unlike that of the Labour secretary of State in England in another critical respect. The fragility of executive power in coalition governments means that ministers whose "accounts" do not satisfy the public and/or their parties' coalition partners are at serious risk of being defeated in the legislature and of losing either their policy

proposals or even their jobs. The effects of these changes on the processes of governance have been outlined above.

The contrast with England is increasingly striking. On the one hand, one of the main themes in the recent rhetoric of reorganisation in England has been the need to decentralise the management of health services by delegating much more responsibility to health authorities, albeit monitored by the new regulatory bodies such as the Commission for Health Improvement. It has been commented [by our Scottish partner] that "the creation of NHS Boards in Scotland and the erosion of NHS Trusts as separate organisations stands in sharp contrast to the English model with its avowed emphasis on decentralised decision-making and the control of resources by Primary Care Trusts."

On the other hand the Secretary of State has, so far, been careful to ensure that in general there are no encroachments on the direct line of internal accountability between himself and health service providers. He constantly employs the language of accountability, but in ways which suggest that he does not understand what accountability means. "National accountability moves away from organising a particular institution around large numbers of targets towards overall systems performance and health outcomes", he declared early in 2002. But he went on to say "Power will be devolved to locally run services." It was perhaps not surprising, given his new focus on "systems performance", that he had nothing to say about devolving any means whereby those deploying such local power could be locally called to account. Perhaps he believed there would be no occasion for this, given his declaration elsewhere in the same speech that "there is little public appetite for diverse standards between local services."

It seems clear that, in general, the only level at which those planning and running health services in England will be publicly accountable will, as before, be that of England as a whole. In striking arithmetical contrast to the situation in the three devolved administrations, the concerns of 50 million English citizens and potential patients can be given political effect only through a centralised system where local candidates run on manifestos drafted at party headquarters, through one Secretary of State and one health committee; debates and questions must struggle to find time in the crowded programme of the parliament of a sovereign state; democratic control must be exercised exclusively through the ballot box in parliamentary elections.

The arrangements proposed in *Delivering the NHS Plan* for increasing the public's influence on health services are something of a ragbag, and their effectiveness seems likely to be highly variable. Even where local authority "overview and scrutiny committees" are dissatisfied with their local health services, their final sanction is to refer the matter upward to the health secretary. He is unlikely to feel seriously challenged: it is rare indeed that concerns about a single service sector, even one as politically significant as the NHS, have more than a marginal influence on electoral results. (The single continuing exception to this, unique in modern British politics, was the salience of the issue of Kidderminster General Hospital in the Wyre Forest constituency. Here a parliamentary victory for the "save the hospital" candidate in 2001 was followed by a similar success in the 2002 local government elections. It remains to be seen whether an independent candidate protesting against the Glasgow hospital rationalisation can cause a similar upset in the 2003 Holyrood elections.)

There is no reason to expect that accountability will effectively be decentralised by any likely future arrangements at regional level. These may in fact have been foreshadowed by the set-up in London. There, despite the arrival of the London mayor and assembly and their general concern for Londoners' health, accountability for London health services is still upward, to the chief Executive, NHS, and his Secretary of State. The May 2002 White Paper on revitalising the regions ('Your Region, Your Choice: revitalising the English Regions', Cm 5511, September 2002), made it clear that even where there are to be regional assemblies, these will have no greater powers than now in relation to health services.

This is probably just as well, from a political point of view. If some regions were to have assemblies to which regional health services were in some real sense accountable, there would be the beginnings of a situation in which the constitutional rights and powers of English citizens would vary according to their domicile. In terms of democratic rights, there would be a two-tier system, in that some people would be able to exercise some control over local health services while others would not. The political risks inherent in such variation are already illustrated by the current campaign to extend to England the entitlements to free domiciliary care for the elderly legislated by the Scottish Parliament. As it is, the formal contrast is already great, and may start to be perceived, between Scottish and Welsh arrangements and those in neighbouring areas across the borders. The First Minister in Wales has declared that Wales will not follow the foundation hospital route. (Hetherington, P, 'Wales goes its own way with NHS reform', Guardian, 15 November 2002).

There is now however, one context in which just such a differentiation of constitutional rights is developing, and one exception to the system of traditional centralised control described above. As already mentioned, in those parts of England served by foundation hospitals (however this relationship may be defined) managers are to be directly accountable to local citizens - probably through some form of proportional representation. (Bizarrely, this means that arrangements to enhance public accountability are to be stronger where, arguably, the need is least - that is, where performance is best: only the minority group of "foundation hospitals" are required to involve patients, staff, the local community and others.) Elsewhere patients and citizens will have to find their way through the maze of overlapping monitoring, scrutiny and standards-setting bodies created under the NHS Plan.

A key term in the current rhetoric is "choice". But choice for what? In all cases local providers will be required to perform to standards, and thus priorities, set centrally. It is striking that the administration in Wales (which had already decided to maintain community health councils, abolished in England) decisively rejected the foundation hospital model, arguing that the Welsh approach was to make the health service more accountable to communities and to treat patients "as partners", rather than as consumers.

If lines of accountability are in fact clearer and more direct in the devolved administrations, what might be the effects of this? The effects can, in principle, be assessed by reference either to processes or to outcomes. That is to say, devolution could lead to changes either in the nature of health services and the ways in which they are provided; or in health status. Two sorts of questions can be asked about impacts of either kind. First, whether

services or outcomes are *different*. This could mean different from what might have been expected in a less devolved, less publicly accountable system, in which greater weight was given to technical considerations and the views of service providers than to public sentiment and to the views of service users. If, in future in Scotland, Wales and Northern Ireland, more attention were to be paid than in the past to local needs, preferences, priorities and values, the result might well be differences in the nature of public services in the different countries, including health. There might also be differences in the cumulative effects of services - for example, differential changes in morbidity among different groups, defined demographically or geographically.

[Our Scottish partner], summing up the experiences there of the past three years, has commented that in monitoring developments there is a tendency to look for divergence in policy, and that brings with it the danger of the analyst being drawn to a focus on the actions of the executive and inadvertently to understate the impact of the Parliament. The routine of parliamentary statements, questions written and oral, committee hearings and the like only catch the public eye at times of controversy, but they are fundamental to the policy making process. The evidence in the quarterly reports shows that these processes have been transformed not only at a national level, but locally as well, as NHS bodies have cause to think carefully about the way they engage citizens and their parliamentary representatives in their work.

The second sort of question that might be asked either about services or about their impacts is whether they are *better*. Once again this could mean better in the sense that they were more satisfactory to citizens and service users, or better as judged by some kind of objective or technical criteria (eg lower morbidity or mortality rates, or the more efficient use of resources, as shown by lower unit costs or higher throughput in larger, centralised institutions). Such criteria might, of course, themselves reflect the views of citizens and service users; on the other hand, they might be determined by experts and adopted unilaterally by the executive without public consultation. In general and in principle, devolution gives voters in, say, Scotland the opportunity to make choices which are appropriate to local (Scottish) circumstances and local values, rather than having to accept a homogenised, "United Kingdom" approach which may correspond to the priorities of none of the UK's constituent countries. (As observed earlier, the Wanless report seemed not to consider the first possibility even worth mentioning.)

This possibility may prompt a more general question of principle. Is health an appropriate field in which to allow for any significant degree of local discretion and local variation? If constitutional lawyers were starting from first principles to design the distribution of functions between the tiers of government in a new federal state, how high should health services rank among those to be devolved - compared with education, transport, housing, the environment, etc? It might be argued that activities involving life, death, degrees of pain and suffering, raise such basic issues of equity and human rights that in this context all citizens should be treated equally: policy decisions that impinge on them should be taken centrally.' If the cost of this is a "democratic deficit" at local

5. See Keith Banting and Stan Corbett. *Health Policy and Federalism: A Comparative Perspective on Multi-level Governance*, Kingston: Institute of Intergovernmental Relations, and McGill-Queens University Press. 2001.

level, that is a relatively small price to pay for fairness. It might also be argued that health is an issue of great concern to most people and thus one on which many voters will have strong views. This is demonstrated by the amount of time devoted to health issues in the devolved legislatures, where the executive has less control over the shape and content of parliamentary business than at Westminster; health's share of business indicates plainly the importance attached to health by local elected representatives. Practical politics might require national politicians to maintain their grip on health policies and practice.

On the other hand it could be argued that there are other sectors in which government action or inaction has equally significant effects on people's life-chances, and where similar issues are raised. Education, for example. Major differences between the Scottish and English systems long predate devolution, and have not been questioned. It could also be argued that the undeniable objective differences in the health status of the four countries of the UK justify different priorities and strategies, that medicine is still such an inexact science that the case can rarely be made for a single, invariable response to specific conditions and that in any case no national UK interest is threatened if local responses do in fact vary.

Perhaps the answer to the question of principle can be derived only from assessing the practical impact of devolution in the field of health. Are people in fact better off - subjectively or objectively - as a result? That is to say, do they feel better, whether about their health services or about their health? Or are they, alternatively or additionally, actually better off in some quantifiable way?

It is far from clear that in this context either the values or the views of the Scots or the Welsh do differ significantly from those of the English. In all countries people dislike lengthy waiting times or poor quality hospital environments. There is no evidence of clear-cut differences between countries of the UK in popular opinion about, for example, the relative priority which should be given to children or the elderly, to drug-abusers or road accident victims, to cosmetic or to life-saving surgery. The public in Scotland or Wales seem no less disposed than their counterparts in England to assume that the solutions to problems of poor health are to be found in better health services (perhaps even in more expensive health services). In all countries, the public tends to identify 'the NHS' with the bricks and mortar of local health service provision, rather than the more nebulous concept of 'health services', defending the former against changes predicated on improving the quality of the latter.

There is no reason to suppose that, in any referendum across the countries of the UK on the rationing of health care, the nationality of the respondents would introduce significant variation in addition to that which would be explained by differences in respondents' age, gender, ethnicity, education, social and economic status, and so forth. Nor is it likely that the undeniable differences in health *status* between the four countries would be reflected in differing priorities being given either to campaigns against specific conditions or to preventive as opposed to curative approaches.

That being so, it could be argued that devolution is *in practice* irrelevant to the substance of health and that, even in the longer term, greater responsiveness to public opinion in the devolved administrations will not lead to significant variations in the standards or in the character of health services, or indeed in their shares of available resources. There will be no effective counter-pressures to the policies formulated and declared by English ministers, in the Department of Health and the Treasury. There will not be distinctive strategies for health or for health services in Scotland, Wales or Northern Ireland.

This last point could be put more strongly. Viewing the events so far, some claim that the freedoms given to the devolved legislatures, and the greater responsiveness of the devolved executives, have produced both processes and outcomes which are actually worse than before devolution. The quality of debate in the legislatures has been described to us as unimpressive, while ministers' closeness to the public and to the arena in which decisions have to be implemented appears often to have had the effect of delaying necessary decisions, or of inhibiting the choice of potentially unpopular options. The cumulative effects of this militate against strategic thinking. The result could be that there will be no country strategies of any kind, merely a series of tactical responses to immediate local pressures.

Finally, will devolution lead to *better health*? Given that health status is the product of a wide range of factors, not simply the effect of health services, devolution would be likely to lead to better health only if its "intermediate" consequences included giving greater attention to the wider determinants of health, to enhanced action bearing upon these and, where necessary, to coordinated (or "joined-up") action. As discussed earlier in this report, there is no evidence that joined-up action, in either the making or the implementation of policies, has proved to be easier or more likely in the devolved administrations than at UK level. We have identified some evidence that suggests that the opposite may be more likely.

One conclusion from this is that, at least in the short run, the justification for devolution, as it affects health and health services, may have to be the classic justification for democracy - that with all its defects it is less bad than alternative systems of government. To put it another way, the outcomes of democratic processes may be technically no better than those determined by executive fiat, but at least they are likely to be regarded by the electorate as legitimate, in which case the continuation of the system is assured.

An additional minor benefit may be the enhancement of the learning process. Devolution should allow for comparisons between policies and practice between the several administrations - if, for example, the English NHS continues to make progress along the lines advocated by Alan Milburn, in which considerable autonomy is delegated to selected operating units, while Scottish ministers continue in traditional centralised mode. Such comparisons should be facilitated by the continuing existence of UK-wide professional networks, which may indeed act as a countervailing force to excessive local divergence and variation. But it is noteworthy that a November 2002 NHS "regional symposium" on *How the English regions are tackling health inequalities and social exclusion* was, as its title implied, confined to representatives of the English regions.

## 8.2 Devolution and Health - a final reflection

When Robert Hazell and Paul Jems produced the first Devolution and Health report for the Nuffield Trust in 1998, they set themselves two tasks. The first was to produce a factual description, using the information available at the time (which was before much of the detail of the legislation was known) about the impact of political devolution on the UK's health services. The second was to offer some tentative hypotheses on the subsequent consequences on issues of health policy, health service organisation and management. In their first report, Chapters 7 (Findings from the field: Making devolution work), 8 (Will there be a developing regional agenda in England?) and 9 (Reflections on our findings) contained these more subjective hypotheses and predictions.

We have revisited much of this material earlier in this final report. Now, in the spirit of the both reflective and speculative nature of the final part of that earlier report, we offer some final thoughts of our own, including a reflection on the extent to which some of the earlier predictions have come about. In doing this, we have adopted the convention that summaries of the first report's content are presented in normal font, while our reflections and speculations are italicised. And finally, again in the spirit of the first report, we pose a set of questions, the answers to which can only emerge as the four UK health systems develop and grow under political devolution.

### ***Making a difference***

We commented that, to judge from the evidence from Scotland and Wales, 'making devolution in health work' was envisaged to be as much a political process as it was a professional/medical one. It was associated with concepts of 'taking ownership' for the national health systems of those countries, and producing something that fitted the culture, traditions and aspirations of the countries. Although, in health, political devolution brought few freedoms additional to those offered by administrative devolution, it was expected to make a difference. A Scottish clinician made the point succinctly:

"Devolution doesn't mean anything unless you do things differently - otherwise why have it?"

We reported a somewhat different view from those in London or with 'London-facing' roles. While sharing the aims of raising health status and addressing inequalities, there was a strong undercurrent in these views that such objectives were best achieved by maintaining a unified 'National Health Service', and thus of resisting any divergence in the health systems in Scotland and Wales.

However, our discussions took place very early in the devolution process. We thought that, with the passing of time, there might be a growing recognition by those who traditionally look to London as the 'policy centre' that the dynamic of policy formation will be different. But we foresaw possible tensions between those who saw the need to resist divergence and those who saw devolution as the chance to be different, and the implications for the operation of the health systems post devolution.

*In some senses, both of these observations have proved to be accurate. In both Scotland and Wales, health has been a major concern of the new Administrations. As we have described above, both the Executives and the Parliament/Assembly in these countries have striven to 'take ownership' of their national health system. Producing something that fits the culture, traditions and aspirations of the countries has underpinned the different 'white papers', policies and strategies. The need to address the wider determinants of health is being addressed in both cases. Indeed, to some, the need to be different has at times gone beyond what is needed in some absolute sense - described to us as the need to 'Welshify' English approaches, or in Scotland as a desire for 'a Kiltmarh not a Kitemark.'*

*The view in the centre is a bit more complex. After an uncertain start, when the DoH at times did not seem to be clear whether it was acting as the Department charged with running the English NHS or on an all-UK basis, its role as the English health department has come strongly to the fore. Most recently, almost the entire focus has been on a blizzard of organisational change and policy initiatives aimed at reforming the English NHS. But the political importance of the NHS in UK politics has also featured strongly - indicated for example by its prominence in the UK General Election of 2001, despite the fact that the Government being elected would have no direct responsibility for the health services in Scotland and Wales.*

*What seems to have happened is that, after some early attempts to control things from the centre, there is now little formal attempt by the centre to resist divergence. What is less clear is how much pressure is put on the devolved administrations behind the scenes, through Labour Party channels, to maintain a common approach.*

*There also seems to have been less effort to orchestrate policy development and/or its announcement. But the dominance of the UK news media by London-based organisations means that the devolved administrations feel they are, from time to time, 'bounced' by Whitehall into policy formation.*

*The English voting public is likely to remain, as now, generally unaware of and indifferent to variations in public policies in Scotland and Wales, let alone Northern Ireland. If the administration in London were sufficiently robust it could, as a matter of practical politics, probably ride out a fair degree of divergence in Edinburgh and Cardiff. That would obviously be compatible with the objectives of devolution. The main question is thus how robust future UK governments will be.*

### ***Diminishing the 'democratic deficit'***

We suggested that a major benefit of the 'return' of the health services to what would be seen as local democratic control would be the diminution of the 'democratic deficit'. We cited the opportunity to overturn the highly unpopular organisational changes introduced by the Conservative government, and the smaller scale of the administrations, and thus the presumed ability to influence political decision-making, as factors which would contribute to this reduction. Among other things, this would bring about an improvement of working relationships between the health services and local government. We have discussed this last point in detail above. We can now summarise the 'democratic deficit' debate.

*As we have discussed, there have been significant changes in democratic accountability in both Scotland and Wales. Whether these address a local democratic deficit is debatable because the dominant pattern appears to be national-level centralisation, as we have described above. Interestingly, the English NHS is now using the rhetoric of decentralisation, and proposing more local participation at least in the proposed 'Foundation Hospitals'.*

*So, perhaps surprisingly, there are signs that the first real experiments in returning some parts of the health services to local democratic control (or, if not allowing full control, giving local people a significant involvement in health services management and delivery) may in fact come in England, through the foundation hospital experiment. Were it to extend only to these 'new' institutions, it would apply selectively and would raise concerns about inequality of governance across England. And the proposals for Foundation Hospital governance seem somewhat at odds with the much criticised replacement in England of Community Health Councils.*

*For Scotland and Wales, the real tests of 'localness' of governance will come, we suggest, when some critical strategic service reconfigurations have to be implemented. It may be, as early indications about the Glasgow reconfiguration suggest, that geographical proximity to a Parliament or Assembly does very little to increase a feeling of local democratic participation. There will be much to be learned about the effectiveness or otherwise of democratic participation on decision-making processes in health from monitoring these different governance arrangements.*

### **Diverging models of healthcare?**

We predicted that there would be no threat to the concept of the 'National Health Service' from devolution, if by the 'National Health Service' is meant the set of core values and principles which have persisted since its founding. But we saw considerable scope for divergence between the three countries in terms of health care planning, organisation and management without abandoning the basic principles on which the NHS was founded.

*As we have argued earlier, there seems to be general acceptance that it is now more appropriate to talk of the UK's family of health services than of 'the UK NHS'. But the effects of this divergence have not as yet had time to work through to impact on the different populations' health status. We did not differentiate between innovation in the policy process and innovation in the content of policy which, as we discussed above, we now recognise as an important distinction. But the biggest difference between our expectations and subsequent developments lies in the locus of health service innovation.*

*Rather than innovation coming at the margin, as we predicted, it looks as if the most radical changes will start in England. If Alan Milburn's vision of a health service based on "the traditional method of funding, but a completely new way of running the service" proves to deliver better outcomes and shorter waiting times than those achieved in Scotland and Wales, it will be interesting to see whether pressure will grow in those countries to copy the English innovations.*

### **Aspirations and resources: Rationing, access and cross-border flows**

We made a number of observations about the operation of the Barnett formula, and how pressures might arise to have it either modified or replaced. We have reviewed these

financial issues in considerable detail above, and will not revisit this discussion here. We also reflected on the possibility of differential approaches to rationing in the different countries, and the possible impact on cross-border patient flows. What we did not discuss other than in passing was how the different administrations might wish to alter the way health funding is distributed within countries.

*In England, Scotland and Wales the formulae for distributing funding have been re-examined, in all cases with the aim of finding a better way of addressing inequalities in health status. The process in Scotland and Wales took place much more in the public eye than in England. In both countries there were early moves to examine the formulae being used - the Arbuthnott and Townsend reports. The proposed Welsh approach appears to be a significant departure from the English and Scottish thinking.*

*The potential for divergence has been exploited — in Wales, prescription charges have begun to differ from those in England (though so far not enough to make significant volumes of cross-border travel worthwhile) and policies for charging for eye tests are different. We have described above the one significant divergence between Scotland and England, over the funding of long term care. In this case, there was pressure both overt and covert to make Scotland hold the 'English' line, but the realities of the political situation in Scotland carried the day.*

*These changes have not - so far at least - led to significant cross-border flows. There has been some talk, largely in the English media, of people in the North-East and North-West crossing the Scottish border to access better funded education and health services. However, geography prevents cross-border flows being a major issue for the majority of the different health services. Perhaps because of the massive increase in health service funding, and because of the rhetoric which condemns 'post-code prescribing', the rationing debate has not developed significantly during the time we have been monitoring events. (The one significant exception, already discussed, is that of the funding of long-term care.) In the longer run, it is inevitable that resources will again fall short of perceived needs, and that the different administrations will have to return to the rationing debate.*

### ***The question of England***

We included a Chapter in the first report on England, despite the fact that at the time of writing the only devolution-related development about which plans were clear was the establishment of a Mayor and Assembly for London. We have devoted a significant part of this report to England, and there is relatively little we want to add here.

Our focus in the first report was on whether the Department of Health might need to adjust to the developing regional agenda in England. We had in mind the fact that the more the Regional Development Agencies widened the scope of their activities, and started to impinge on some of the key areas affecting people's health (such as housing, transport, physical regeneration etc), the greater would be the need for effective collaboration with the NHS.

*Looking back on developments over the past four years we see a mixed pattern. As we have stated frequently, there has been, and continues to be, massive change within the English health care service but developments affecting any regional role in the wider health agenda have been*

*significantly slower. However, the most recent indications are that the regional devolution process may accelerate, with consequent implications for the English NHS.*

*We discussed the importance of co-terminosity between NHS and other major stakeholders, especially local authorities, to facilitate 'joined-up working'. It is a sign of the speed of change that some of the possible changes we identified have both come and gone. We cited the recommendation of the Tumberg review of London's health services that a single London regional office for the NHS Executive should be the longer term aim. Although the 'NHS Executive' no longer exists, the Department of Health did establish a single body for London, most recently tenned the London Department of Health and Social Care. But with the establishment of five separate Strategic Health Authorities to cover the Greater London region, the DHSC is to be integrated into the central Department of Health. At the time of writing it is not clear whether there will be any pan-London NHS organisation that will relate to the London Mayor and Greater London Assembly, although there will continue to be a single Director of Public Health for London.*

*Nor is there to be any co-terminosity of regional boundaries outside London. Once the Department of Health's Regional Offices have been integrated into the Department, all that will remain will be the Strategic Health Authorities, which each cover two or more counties. These StHAs are to become the 'local headquarters' of the NHS, and thus each English Region will have several within its boundaries. The one remaining regional health function, the Regional Director of Public Health and some staff have been relocated to the Government Offices for the Regions (interestingly, not to the Regional Development Agencies). One positive aspect of this is that it may provide an impetus for 'joining up' on the wider health agenda.*

*In terms of the place of health within a more devolved English governance model, the signs therefore are mixed. However, it seems that much of the thinking about health services is moving from 'central' to local' without any 'regional' role, in the sense that regions are recognised in other areas of policy. There are some who doubt whether the StHAs have the 'critical mass' both in population terms and expertise really to be strategic. A cynic might predict that StHA mergers a few years hence will once again re-create a regional structure for the English NHS.*

### **Relationships with Europe**

One area on which the first report shone a spotlight was that of 'international relations' in general and contact with Europe in particular. The formal position which we described, that formal representation in Europe is a matter for the UK and will be managed by the Department of Health, has not changed and will not do so.

*We signalled this area as a potent source of conflict post-devolution, but we are glad to be able to report that major difficulties here have been avoided. It might even be that the publication of the Nuffield Trust's first report and the attention it drew to the Department of Health's need to prepare for its new role in inter-governmental relations played some small part in smoothing the way ahead.*

*In the years since the first study, the influence and importance of the European Commission's effect on health policy has increased dramatically, In the main, so far, this has been because of actions in non-health policy areas - the incorporation of the ECHR in UK law, court decisions*

*about the free movement of good and services, the impact of the working time directive, and so forth. As we commented above, to date, it is only the English NHS that has been seriously wrong-footed over this. However, the devolved administrations will increasingly need to be mindful of European imperatives of one sort or another as they develop their health policies.*

### **Support for the policy process**

We suggested that, post-devolution, the development of both policy and practice would need to be supported by a strong policy analysis and policy development capability. This would be needed both inside the government machinery and also *outside*, in independent 'think tanks' or research units. Since most of the existing policy and research institutes were based in England, and tended to focus on English or UK issues, we felt that there the devolved administrations might experience a capacity shortage. We also noted that capacity within the (then) Welsh and Scottish Offices had been reduced, particularly in the former, by previous administrations.

*The workload pressures on the Scottish Executive and National Assembly for Wales have been considerable, as mentioned earlier. In part this has come from having a much larger scale political administration to support, and partly by the increased workload caused by needing to service the Parliament and Assembly, their Committees and the new elected members. Steps have been taken to increase capacity within the relevant civil services.*

*Outside the government machinery, the market has moved relatively rapidly to increase policy capacity through the development of new policy and research bodies. All sections of the 'Lobbying' industry rapidly realised that there are now multiple centres of power/influence, and recognised that they need to face towards all of these, not just London/Whitehall. New policy units, both within higher education and independent organisations, have been established. It is not just the 'policy community' that has recognised the need to relate to these multiple centres of power. The professional institutions, Royal Colleges and other representative bodies, also have changed their structures and processes in order to operate in the new devolved environment.*

### **Politicians, managers, professions and the locus of power**

We reflected the concern that had been reported to us, that devolution might lead to the fragmentation of all-UK professional networks. There was a concern that, if devolution did lead to a fragmentation of professional networks, this would lessen their value for the English as well as disenfranchise Scotland and Wales. Opportunities for learning and sharing good practice and innovation would be lost.

*Again, this is an area in which the evidence points in different directions. There is little evidence that there has been any significant deterioration in the performance of all-UK networks in sharing information and supporting professional development. But there are some signs that the power and influence of professional bodies on policy matters may have changed slightly.*

*When we were examining changes in governance and accountability, we naturally were interested in issues of power, and any shifts in relative power that appear to have resulted. The evidence from Scotland and Wales suggests that what appears to be taking place is not so much a*

*shift of power from professionals to another group such as managers, but rather a centralisation of managerial power in the Health Departments of the devolved administrations. The organisational changes introduced since devolution by the administrations in Scotland and Wales would lead one to expect this response. There is an accumulation of evidence which indicates that the main administrative consequence of devolution have been to increase the managerial power and efforts of the central administration of each country.*

*It is interesting to speculate on whether there is now developing a different trajectory in England. There would probably be little disagreement that the first years of the Labour administration were accompanied by a massive centralisation of power. This was demonstrated, among other things, by the abolition of the separation between the Department of Health and the NHS Executive, and the introduction of an extensive array of performance imperatives and performance indicators. But more recently, as we have discussed above, the emphasis has been on decentralisation of power to the front line', and a change from a 'command and control' model to a 'regulated' one. It is too early to attempt to judge whether the reality as experienced by managers and professionals in the service will reflect this rhetoric.*

*In terms of the relative power and influence of different groups, a tentative conclusion is that some are better able to represent themselves on the UK level, and others on the devolved level. Devolution changes the balance of power by changing the balance of importance between the different policy levels, UK, county, region and so forth. Those groups that formerly worked most effectively at the all-UK level might suffer.*

*By and large, the 'winners' perceived by health professionals close to the policy process in devolved politics are not the professionals or the professional organisations; they are the civil servants, the devolved politicians and the devolved media. The implications are that, at a minimum, the professionals bodies must look to work through one or more of these 'winning' groups. At a maximum, it suggests that the professional bodies may have lost at least some influence.*

### ***The impact of devolution on workforce issues***

We noted the potential for divergence in approaches to various 'human resource' policies, for example terms and conditions for medical professionals. We questioned whether changes introduced, for example, by the English health service, might disadvantage Scotland and Wales. We wondered whether and how the policy machinery would cope with the different national perspectives, particularly given the dominance of the English health service as an employer.

*Our monitoring has confirmed that this is an area where in due course devolution may bring significant pressures. However, to date the impact has been relatively minor. In the intervening years, workforce issues, particularly recruitment and retention, have been a major concern for all administrations. As yet, there seem to have been few major difficulties (or differences) between different administrations. Perhaps the most significant development has been the recent rejection by English consultants of a new contract which their Scottish and Welsh counterparts would have accepted.*

*The biggest concern for the devolved administrations has been that initiatives have been introduced in England (for example, additional payments to GPs) which have knock-on consequences for them, but without prior consultation or even warning. It is likely that such initiatives will generate more pressures in future.*

### **8.3 Devolution and health - looking to the future**

We concluded our initial survey, from which this project derived, with a list of questions which might be addressed in such a project. (These questions, now<sup>7</sup> mainly of historical interest, are at Appendix I.) Our monitoring activities are now at an end, but were we to continue, we would suggest that there are a number of questions that might be considered:

- Will aspects of health and of health services in the devolved administrations become issues of contention in UK politics and especially in UK elections?
- Would changes of party control in the devolved administrations and/or in England widen the health policy gap between the countries; and could this generate tensions in inter-governmental relations?
- If there were such changes, would policy issues be discussed more openly and transparently between the several administrations than has been the case so far?
- Regardless of continuity or change in health policies, might differences in the political contexts lead to differences in citizen satisfaction with health status and health services?
- Will any of the experimentation with a 'mixed economy' of provision of English healthcare (NHS organisations, voluntary sector bodies, private sector organisations and overseas providers) lead to pressure on the devolved administrations for similar experimentation?
- Will the local accountability mechanisms proposed for the English Foundation hospitals lead to pressure for more local accountability for other parts (by far the majority) of the English NHS?
- If there were further "scandals" in the privatised English hospital sector, would comparisons between practice in England, and in Scotland and Wales, become a political issue?
- Will developments in regional devolution in England lead to further pressures on the English NHS to become more accountable locally or regionally?
- Might existing differences in policy and practice be amplified by the differences in accountability arrangements, for example the continuation of CHCs in Wales?
- Will the Welsh Assembly wish to increase further the "distance" between policy and practice in Wales as compared with England? If so, will the Assembly wish to argue that it should have legislative powers equivalent to those of the Scottish Parliament.
- Will the availability of treatment in other countries of the European Union lead to a "flight from the NHS" and might the rate of such a flight vary between the countries of the UK?

Political devolution in the UK has altered the landscape of the health services. We predicted originally that it would lead to more, and more rapid, divergence in policy and practice than many people expected. In this report we have tried to do justice to the many different facets of health and health services policy in the UK today. Devolution has sowed the seeds of many developments; the full impact of these is both difficult to predict and, in any case, lies some time in the future.

We titled the last Section of Chapter 7 of the original report 'different', not 'better' or 'worse'. We believe the spirit of that phrase should still inform the way the four UK countries' approaches to health and health care policies should be viewed. We wrote in the first report that all the health services faced major challenges, stemming in large part from the demographic and economic realities. The financial pressures we cited then may have receded somewhat, so the requirement may not be to do more with less, as we then said. But there remains an urgent imperative for continuing innovation in the face of the challenges.

In principle, political devolution has now granted the different countries the ability to develop and own their particular responses to the health challenges they face. Each country has some particular problems of its own, but there are many shared problems - such as 'pockets' of deprivation and extremely poor health status. In a crowded island, everyone has the potential to make life more - or less - difficult for his neighbours. The need to share and learn as people tackle the important endeavour of raising health outcomes is stronger than ever. We hope that by illuminating the early steps taken on the paths of devolution in health we may have contributed a little to this process of mutual understanding and learning.



# **APPENDIX 1: QUESTIONS POSED AT THE END OF THE FIRST DEVOLUTION AND HEALTH REPORT**

- How will the Scottish Parliament and Welsh Assembly influence the development of health policies and strategies? Will their activities focus on strategic leadership or will tactical issues of audit, supervision and accountability dominate?
- Will the different political parties use the proportional representation system for electing members of the Scottish Parliament and Welsh Assembly to ensure that health (and other) experts are included?
- Will Scotland and Wales, with their characteristics as 'policy villages' prove more effective at avoiding the 'functional chimneys' of public policy than the UK government has, thus delivering 'joined up government'? What mechanisms will be developed to achieve this?
- If, as is likely, resources are limited, will Scotland and Wales develop more effective, and more publicly acceptable, ways of addressing 'rationing' decisions, either within health or between health and other priority areas?
- Will the English health service be able to play the full part in the development of regional economic and other strategies that their partners in the regions require? Will Regional Development Agencies and Regional Chambers be able to engage appropriately with the debate on health policy, priorities and resource issues?
- How effectively will UK-level health policy be conducted, e.g. in respect of European and other international matters, and in those areas which are 'reserved'? Will the principle, or the detail, of 'reserved' powers come under pressure? Will both the politicians and

the health professionals be content with the mechanisms used and the policy outcomes?

- How, if at all, will the various health and health-related professional bodies adjust their governance structures and operating methods to reflect the post-devolution situation?
- How will professional bodies' involvement in UK-level policy development be secured post-devolution, and will the health professionals in Scotland and Wales consider the mechanisms appropriate? Will there be increasing pressure for separate professional bodies in the three countries?
- Will UK professional bodies/associations still provide an effective way of learning from innovations in policy, practice, organisation and management across England, Wales and Scotland?

# APPENDIX II: COUNTRY REPORTS

## I. Scotland

### *Looking back*

In monitoring events over the past two years there is a tendency to look for divergence in policy and that brings with it the danger of the analyst being drawn to a focus on the actions of the executive and inadvertently understate the impact of the Parliament. The routine of parliamentary statements, questions written and oral, committee hearings and the like only catch the public eye at times of controversy, but they are fundamental to the policy making process. The evidence in the quarterly reports shows that these processes have been transformed not only at a national level, but locally as well as NHS bodies have cause to think carefully about the way they engage citizens and their parliamentary representatives in their work.

As new political actors adjusted to new roles it was perhaps inevitable that these 'process' matters dominated the first year of the Parliament and the Executive. Moreover, the dominant party in the Parliament had to call at short notice on understudies to fill the leading role following the sudden death of Donald Dewar and the resignation of Henry McLeish, events that dramatically interrupted the emergent ebb and flow of political debate. The new political actors also inherited a substantial health policy legacy, only partially implemented, and so it is unsurprising that it was primarily in the second year of devolution that policy substantially different from elsewhere in the UK, begins to emerge. Three policies stand out in this context: the governance of the NHS; the role of the private sector in the delivery of publicly funded health care; and free personal care for the elderly.

It is increasingly clear that the health services of the UK are developing quite different models of governance. The creation of NHS Boards in Scotland and the erosion of NHS Trusts as separate organizations stands in sharp contrast to the English model with its

avowed emphasis on decentralized decision making and the control of resources by Primary Care Trusts. Similarly, the enthusiasm of English ministers for more participation by the private sector in care delivery is not apparent in Scotland (or Wales and Northern Ireland).

Although there has been, and continues to be, a vigorous debate about the role of the private sector in health care delivery, it was the subject of free personal care that caught the popular imagination. An emotive subject, it produced high drama in Scotland's Parliamentary chamber, and offered an insight to the machinations of post-devolution inter-government relations. As the First Minister fought off opposition from his reluctant Labour colleagues in his Cabinet, exploiting the new dynamics of coalition politics to force his policy on them, questions arose about the justice of elderly people in one part of the UK enjoying a benefit unavailable elsewhere. Is this the shape of things to come or did the public display of high-level political intrigue have a mesmerising effect on commentators who endowed the events with an unjustified significance?

In the meantime, more immediate health 'events' in Scotland unfolded at an increasingly rapid rate, as a range of Executive inspired initiatives respond to official reports, operational crises, and the new possibilities of record resources. In many respects the events of the last quarter of 2001 were the most eventful of the year and perhaps even of the lifespan of the Devolution and Health Monitoring project. Scotland saw the appointment of its third First Minister since May 1999, and a new Minister took over the health and community care portfolio. The new cabinet was instructed to focus on current priorities in their portfolios suggesting that major changes of direction in health policy are unlikely, the focus instead being on the delivery of existing commitments. Most of these were set out in the Scottish Health Plan, which celebrated its first anniversary in December 2001.

During the quarter the key areas of activity were tackling waiting lists, the use of the private sector in Scotland, and identifying funding for free personal care for the elderly. All three issues generated a great deal of heated debate in Parliament and considerable comment and speculation in the media, particularly the use of the private sector in the treatment of NHS patients. New initiatives were announced on mental health and bed blocking, the recruitment and retention of nurses, and the first heart care standards were also published. On the operational front, the 15 new unified NHS Boards officially went live' across Scotland and the Scottish Cancer Group released an implementation plan following the publication of the cancer strategy in July. However, this was somewhat overshadowed by consultant resignations at Scotland's largest treatment centre for cancer in Glasgow.

### ***Looking ahead***

Looking to the future is hazardous; there are so many variables it is virtually impossible to offer measured comment. But there is one issue that tempts speculation: it is the growing influence of the European Union, generally, and specifically in health care, a theme discussed in the IPPR paper referred to above. As we live through an era when there is understandable pre-occupation with health care events in Scotland, it may be that those who read these monitoring reports in the future are struck by the absence of reference to

European political institutions, which in a decade might have become as influential in health as they are in fishing. If it is increasingly appropriate to speak of the UK's national health services rather than its NHS, the time may be coming when it may be appropriate to reflect on the relative role in health care of political institutions at the regional, national, and European levels.

## II. Wales

### *Looking back*

Has devolution led to divergence in health policy in Wales? The Assembly's health policy was largely determined prior to devolution, with its commitment to tackle inequalities in health set out in *Better Health - Better Wales* in 1998. Wales has wholeheartedly followed Westminster in its decisions to increase NHS spending. Areas of divergence in policy are dominated by the Minister's decision to abolish Health Authorities, to centralise many activities of Health Authorities and devolve others to Local Health Boards. Other areas of divergence are Wales's commitment to pursue the expected prioritisation of elective waiting lists and its commitment to extend free eye tests to vulnerable groups. It may be argued that it is England that has diverged from Wales and Scotland on certain issues such as its commitment to explore the potential of the Private Finance Initiative as an alternative means of funding future NHS capital developments. Wales and Scotland, with their more communitarian commitment to public finance of public services, may be more reticent to tread down this path.

There is evidence that greater joint working between the NHS and other agencies such as local government and Social Services has strengthened at ground level since devolution. It is less clear that joint working has strengthened within the Assembly at policy-making level. This was most evident in the recent review of the NHS funding formula and the dual approach proposed by Professor Peter Townsend to tackling inequalities in health. Professor Townsend stressed the need to reallocate resources within the NHS to the most socioeconomically deprived areas of Wales with the worst health experience, but also stressed the need for a second approach across government to promote economic prosperity, improve poor living and working environments and promote healthy lifestyles. There was little communication during the review period between the various committees responsible for health and social care and economic development, though each independently recognised their potential role in tackling inequalities in health.

The National Assembly for Wales inherited significant overspends by a number of Health Authorities in Wales. This was largely overcome by significant increases in NHS spending both at a Westminster level via the Barnett formula, and at an Assembly level. Jane Hutt's recent commitment to wipe out deficits of the soon to be formed Local Health Boards, particularly those in the South Wales Valleys, means that over time it will be difficult to judge to what extent financial management in the NHS has improved or deteriorated since devolution. The Review of the Resource Allocation Formula in Wales has, since devolution, highlighted the need to improve both finance and activity information systems in the NHS.

It may be argued that if devolution has not made the NHS itself more accountable to patients and the general public, then it has made the Assembly more directly answerable to patients and the public, largely via television and political programmes such as *The Dragon's Eye* and media focus on health policy. Individual Assembly Members are answerable to their constituents for decisions about the reorganisation or closure of health services in their local area. This makes strategic planning as to the future location of acute and district and community services across Wales difficult when no Assembly Member is going to support a proposal that threatens a facility in his or her constituency.

Much data on morbidity, mortality and health service utilisation is only available up until 1998/99. It will be another three or four years until it is possible to examine trend data in order to establish whether the health of the people of Wales has improved post-devolution. Even if it has, then it would be difficult to identify whether such an improvement has resulted from changes in health care policy, and, more specifically, from the Assembly's promise to deliver a "Welsh way", an NHS tailored to the specific needs of the Welsh population, or whether the small signs of economic regeneration (increases in workforce participation, falls in unemployment and increases in disposable income) are helping to alleviate the root socioeconomic causes of inequalities in health.

The job of any Health Minister following the establishment of devolved government will be difficult. Jane Hutt has set ambitious targets for the NHS and, more widely, for improving the health of the population of Wales. She has fostered a culture of consultation and coped well with media criticism.

### ***Looking forward***

It is said that a week is a long time in politics, but evidence shows that three years is not a very long time to see the results of devolved policy-making. The National Assembly for Wales inherited an NHS which had experienced real reductions in both capital and revenue expenditure, a population with relatively poor life expectancy, relatively high morbidity, and significant inequalities in health and socioeconomic determinants of health across Wales. Devolution has enabled the National Assembly for Wales to put into place a mechanism for making health policy and for fostering a culture of consultation. It has also ignited a Welsh consciousness and a nation's sense of responsibility for its own health.

It was, however, interesting to note that Edwina Hart, the Assembly Minister for Finance, found it necessary to follow England's example to the letter by committing Wales's share of a windfall of almost £50 million announced in February 2002 to an expansion on spending on health services. This money was not ringfenced and could have been arguably spent by other government departments either to boost the Welsh economy directly or to improve health through housing, transport or environmental initiatives.

As in other regions, there is arguably something of a reality gap between the optimism of the Minister and her ambitious commitments for service improvement and the very real capacity and manpower crisis being felt on the ground by health care professionals, Trust managers and directors of finance in the NHS. While welcoming additional promises of

resources for the NHS, health service managers and directors of finance have warned that they may not be able to meet the ambitious policy objectives of the National Assembly for Wales and may only be able to operate the NHS at its present levels of services. Perhaps, as argued in the *NHS Plan for Wales*, it will take time.

Meanwhile, although several steps behind England, the National Assembly for Wales has opened discussions of the potential future use of PFI to fund capital development in the NHS. The Minister for Finance, Edwina Hart, reaffirmed the Assembly's commitment to public health care and, adopting what she called a "Welsh way", has changed the term PFI to investment through public/private partnerships in Wales. Some experts have warned of the lack of evidence of the benefits of PFI over public finance. However, it may prove difficult for the Assembly to resist PFI on ideological grounds if, over time, the publicly funded capital stock of Welsh hospitals looks progressively shabbier alongside new, shiny, if costly, PFI hospitals in England.

But this is an NHS suffering from 'change fatigue', facing yet another major reorganisation which many doubt will bring the improvements promised by the Assembly. One cannot help but wonder what the NHS in Wales would look like today if the Minister had honoured the Coalition commitment to a period of stability to allow the NHS to try to meet its priorities for patient care.

### **III. Northern Ireland**

#### ***Looking back***

During the period covered by this project there has been a growing sense—particularly in the Assembly's health committee—that the responsible Minister, Ms de Brun, is floundering. Part of the difficulty has been the general absence of preparedness of all ministers after the long decades of 'opposition' under direct rule. Disconnected from the British party system, with elections being fought on a one-item agenda and with the media obsessed with 'security' concerns, the parties had no incentive to develop sophisticated policy portfolios.

Secondly, and partly as a result, the parties to the Belfast agreement were happy to agree upon a unique system of executive formation whereby ministries would be allocated on the basis of the number of seats held in the Assembly. While this guaranteed all the main protagonists (including the anti-agreement Democratic Unionist Party) positions in government, it also introduced a degree of uncertainty in the allocation of Departments.

When Ms de Brian's 'turn' came, there were only two of the ten briefs left (the other, agriculture, went to the other woman then in the executive, Brid Rodgers of the SDLP).

The Belfast agreement nominally ascribed to the Northern Ireland Assembly a powerful system for bringing the Executive Committee to account, via its statutory committees, shadowing each of the 10 departments.



# CONTENTS

	Page
Foreword.....	5
Acknowledgements.....	8
Executive Summary.....	9
1. The Devolution and Health Projects.....	13
1.1 Introduction.....	13
1.2 Background to the Constitution Unit's work on Devolution and Health.....	13
1.3 The aims of the Devolution and Health Monitoring project.....	15
1.4 The aim of this final report.....	17
2. Health in the UK: where are we now? Varying interpretations.....	19
2.1 Introduction.....	19
2.2 Main Developments and Issues.....	21
2.3 Culture and Conduct.....	22
2.4 Connection.....	22
2.5 Cash.....	23
2.6 Collaboration and the Centre.....	24
2.7 Cooperation.....	24
2.8 The Scope for Learning.....	25
3. Governance and Accountability: divergence develops.....	27
3.1 Introduction.....	27
3.2 The NHS pre-devolution.....	28
3.2(a) Governance.....	28
3.2(b) Public accountability and oversight.....	29
3.3 Health services post-devolution.....	30
3.3(a) Changed arrangements.....	30
3.3(b) Overview - executives and legislatures.....	40
3.3(c) Joined-up government.....	41
3.4 The experience of devolution - the views of health professionals.....	43
4. Health service reform in England: 'Transformation' not 'consolidation'.....	47
4.1 Innovation.....	47
4.2 Principles.....	48
4.3 Management and organisation.....	49
5. England and the UK NHS: resources and priorities.....	55
6. The UK: the role of the professions.....	59
6.1 Introduction.....	59
6.2 Further changes in structures and processes.....	60
6.3 Problems and challenges.....	62
6.4 The professions' dilemma summarised.....	63

7. The European issue.....	65
7.1 Introduction.....	65
7.2 Working Group on the Internal Market and Health.....	66
7.3 Key policy questions for the future.....	68
8. Conclusions.....	69
8.1 Accountability and outcomes.....	69
8.2 Devolution and health - a final reflection.....	75
8.3 Devolution and health - looking to the future.....	82
Appendix 1: Questions posed at the end of the first Devolution and Health report.....	85
Appendix II: Country reports.....	87