DEVOLUTION AND HEALTH

Paul Jervis

The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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Published by
The Nuffield Trust
59 New Cavendish Street
London W1G 7LP

Telephone: 020 7631 8450
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Email: info@nuffieldtrust.org.uk
Website: www.nuffieldtrust.org.uk

Charity number 209201

ISBN-13: 978-1-905030-25-5

Typeset by Liquid Design and Communications Ltd
Website: liquid-dc.co.uk

Printed by Q3 Digital/Litho, Loughborough, Leics.

Contents

Acknowledgements 4

About the author 5

Preface 6

Executive summary 7

1. Introduction 9

2. The role of this report 14

3. Northern Ireland 19

4. Scotland 42

5. Wales 66

6. England and the United Kingdom 85

7. The impact of policies for public service reform 94

8. The impact of European developments on UK health policy 107

9. Conclusions and reflections 116

Acknowledgements

I am indebted to many people who have made this work possible. The Nuffield Trust was one of the first organisations to identify the potential impact of devolution on the UK's health systems, and has provided invaluable support and encouragement over the years. The support of the Trust's Trustees is also gratefully acknowledged. I benefited greatly from my time as a Visiting Senior Research Fellow at the Constitution Unit of UCL, from working with Professor Robert Hazell on the first devolution and health study and from the enjoyable and informative collaboration with William Plowden during the monitoring exercises of 1999 to 2002. It was also a great privilege to act as facilitator of the Nuffield Trust's Council of the Isles Health Conferences held between 1998 and 2006.

In carrying out the research for this report very many senior people from the health systems of England, Northern Ireland, Scotland and Wales gave most generously of their time in discussion with me. Of necessity they must remain anonymous, but they know who they are, and I am greatly in their debt.

I regret that the publication of this report happens a few months later than originally planned, the consequence of the July 2007 floods which destroyed my office (although fortunately not the electronic copies of my notes). I hope the delay has not negated the value of this account. I alone am responsible for any errors of fact or interpretation which appear here.

Paul Jervis
December 2007

About the author

Paul Jervis is an independent consultant and writer. He has a portfolio of academic and consultancy appointments in the areas of management and organisation development, innovation and technology transfer, health services policy and management, and public policy development.

Paul held senior management positions in Business Schools in Oxford, Bristol and Durham. He then joined the Office for Public Management where he worked with both commissioning and provider organisations on strategy and organisational development. He contributed to the Office for Public Management's work on behavioural simulations, used to test out the consequences of new national policies and strategies, both in the UK and Canada.

Paul was a Member/Non-Executive Director of the Oxfordshire District Health Authority for nine years and was a Visiting Fellow of Green College, Oxford. He is a member of the Governance Committee of the Royal Pharmaceutical Society of Great Britain.

Paul has been involved in the Nuffield Trust devolution project since its inception and has co-authored several major reports on the topic, published by the Trust. For eight years he helped to organise and facilitated the Trust's annual Council of the Isles Health Conference.

Preface

Since 1997, as part of its interest in the changing role of the state as it responds to 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. The previous report, published in 2003, asked a series of questions about the trajectory of health policy within the UK's four health administrations. This new report describes the main features of health policy since that time, and reports on conversations with senior health leaders and policy-makers, to reveal their views on the state of play in each of the devolved administrations. It returns, in the final chapter, to the questions asked earlier about the direction of health policy across the UK, and examines the strength and limit of policy divergence under the different pressures of national devolution, UK NHS values and the adoption of EU-wide standards.

It is published in parallel with a work on the values of the UK's four national health services, which analyses how evolving health policies may reflect differing, as well as shared, national values. It is hoped that together, these two publications will provide some important insights into the current state of devolved health policy, and some suggestions for likely future policy directions and the values that underpin them.

Kim Beazor
Chief Operating Officer
The Nuffield Trust

Executive summary

Many commentators have argued that devolution in the UK offers a rare opportunity to observe the evolution of four health systems, each starting from a common base. A previous report, published in 2003, asked a series of questions about the trajectory of health policy within the UK's four healthcare systems. This report focuses on how the health systems in the UK's three devolved administrations have evolved, and how their approaches have differed from those in England, in the period since the 2003 report was finalised. Ten years after the inception of the Nuffield Trust's devolution project, the report describes the main features of health policy since that time and reports on conversations with senior health leaders and policy-makers, comparing this anecdotal evidence with that of public opinion polls.

The report concludes that there are indeed forces for divergence among the UK's different health systems, as the Trust's previous reports have found. But it also identifies a number of forces which might lead to their re-convergence, forces which may have become stronger in recent years. There is now a contest between the forces of divergence and convergence, the outcome of which is not clear. The final chapter addresses the direction of health policy across the UK, and examines the strength and limits of policy divergence.

While not all the questions asked in 2003 can yet be answered, some important conclusions are beginning to emerge. These include the findings that:

- some real policy differences have begun to emerge, for instance free personal care for the elderly in Scotland and free prescriptions in Wales
- many of the policy differences appear to be based on a greater emphasis on 'citizenship' in the three devolved administrations, with less enthusiasm for choice, contestability and plurality of provision than in England
- the impetus for policy divergence either is causing, or has the potential to cause, political tension between Westminster and the devolved administrations, especially while there are governments of different political colours in power in the various countries
- the emergence of a greater role in health for the European Union is, in some policy areas, providing a counterweight to trends towards divergence
- the increased importance of a European role in health policy, together with political diversity within the UK's administrations, suggests the need to build a separate identity and role for the UK health department, and to introduce greater transparency in the conduct of intergovernmental relations in health.

Equally importantly, the report confirms the findings of others that comparative information is hard to come by, making comparison of the performance of different health systems difficult.

Taken together, the findings in this report suggest that the 'devolution experiment' is indeed an important one, both in ensuring that the UK's health services continue to evolve to meet local and national need, and in enabling all the UK's health services to observe and, where appropriate, mirror or adapt good practice to suit the needs of their own populations.

1. INTRODUCTION

1.1 The Nuffield Trust and the role of the state in healthcare

The Nuffield Trust's mission is to promote independent analysis and informed debate on UK healthcare policy. In its recent programmes of work, a major focus has been on the role of the state in healthcare. This is an overarching concept that draws together a number of strands of the Trust's work, including financing and the private/public mix, equity of access and devolution. The Trust has an ongoing programme of engagement with relevant stakeholders which focuses on critically analysing Government policy and assessing the use of alternative, non-governmental, interventions.

The Labour government that came to power in 1997 had pledged to introduce political devolution to Northern Ireland, Scotland and Wales, subject to the results of referenda in those countries. The Nuffield Trust was one of the first organisations to draw attention to the potential impact of this for health and health services. Late in that year the Trust commissioned the Constitution Unit of University College London 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 research for this first report was carried out before the Westminster Parliament had passed the legislation introducing political devolution in the UK, and before the Scottish Parliament and Welsh and Northern Irish Assemblies had commenced operation. The report of this work[1] found that there was potential for divergence between the health systems of Scotland, Wales and England (as is discussed below, Northern Ireland was not covered by this first report).

The authors concluded that the core values and principles that underlie the NHS in England, Scotland and Wales were unlikely to be adversely affected by political devolution. They found at that time that there was little evidence that Scotland and Wales would develop significantly different models of care from those used in England. Nor was it likely that practice in the English NHS would be much influenced by developments in Wales and Scotland. Nevertheless, there was scope for considerable innovation and experimentation in the different countries, particularly in organisation, management and service delivery. It would be essential to ensure that learning from any such experimentation continued to be shared across the United Kingdom health systems. The report identified a number of potential difficulties between the different health

systems which could arise post-devolution, and discussed possible responses to these (Sections 10.6 to 10.12).

How much divergence actually developed was expected to be the result of the interplay between a set of factors which indicated a 'little change' scenario and another set which might signal a more radical divergence. The competing sets of factors both included political, professional, technical and attitudinal components. The future evolution of the three health services would be determined by the interplay of these factors. While it was too early to say which of the scenarios, little change or more radical divergence, would dominate in the longer term, Hazell and Jervis noted that probably the most important single factor influencing this would be the quality of the new political leadership in Scotland and Wales.

1.2 The Nuffield Trust series of *Devolution and Health* reports

The findings of the first report led the Nuffield Trust to support a series of subsequent investigations of the developing impacts of political devolution. On the commencement of political devolution, the Nuffield Trust sponsored a second project. This was a three-year monitoring exercise to track 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 which resulted from political devolution.

The Constitution Unit carried out the monitoring exercise with research partners across the UK. The quarterly monitoring reports from the monitoring teams remain accessible via the Constitution Unit's Devolution and Health website.[2]

Annual reports of the Devolution and Health monitoring project were published in 2000[3] and 2001[4]. In autumn 2003, a final report on the monitoring exercise was published with some more extended reflections and comments about possible future developments.[5]

Taken together, the studies have tracked how devolution has created distinct differences between the health services of England, Scotland, Wales and Northern Ireland, initially in terms of organisation and management, but increasingly in terms of policies and priorities. They have documented the emerging opportunities and challenges for what has now come to be described as the family of health services in the United Kingdom.

1.3 The roots of divergence between the UK's health systems

If the devolution monitoring studies had identified growing divergence between the four countries' health systems, they had not been sufficient to describe the deeper reasons why such differences were arising, nor to assess whether these differences were likely to be permanent features of the UK landscape or transitory features until some new equilibrium was established. The extent to which the roots of divergence could be identified in the trajectories along which the different health systems had developed prior to devolution was reviewed by Greer in 2001,[6] who noted that:

Due to their shared heritage of the UK-wide NHS, all four systems began with similar raw materials and similar new focuses on the professionals' causes of quality and public health.

He commented that the plans then extant were differentiated along two major axes, the extent to which the health service is designed to permit deliberate planning of resources, and the extent to which health policy includes the wider determinants of health beyond the health services. This axis involves attention to health outcomes as against health service outcomes, while the first deals with the extent of the use of planning versus market-based strategies.

Greer noted how the targets and objectives in the English plan were targets for traditional health players such as hospitals and clinicians. The Welsh plan, by contrast, targeted outcomes and regarded the NHS as a tool in the policy mix. The Scots at that stage, he asserted, were in the middle with a plan conceptually structured as the English, with a focus on how healthcare services were delivered, but containing long lists of the ways the healthcare system should reach out from its core functions to promote improvements in health.

As Greer cautioned, his analysis addressed the outcomes of policy-making, but did not directly attack the policy-making processes. Nor did it address the speed and efficiency of implementation or the unforeseen consequences of policies. Finally, it did not examine the extent to which budgets reflected the priorities identified. A major feature in all systems was that of the relationship between the political and healthcare spheres. In each devolved administration he found there had been a tradition of 'autocratic' policy marked by an elite-led form of decision-making in which the professions, civil servants and other stakeholders dominated the closed arenas within which most decisions were taken. A major impact of devolution was an upsurge in political intervention in, and accountability for, the health services. Greer saw this as having both positive and negative effects – positive in that for the first time the devolved health systems were accountable to elected officials, negative in that members of the health services might adjust poorly to 'micromanagement' by the ministers and parliamentarians/assembly members of devolved governments.

Greer concluded that a comparative study of the different trajectories would reveal that the pattern of changes in each of the devolved administrations reflects the society and it's political system. This was what made it rewarding to study the logic of policies despite all the rhetoric that surrounded them.

1.4 The impact of values on health systems

The 'natural trajectories' along which the different health systems have been developing have their roots in many things, including the national cultures and values of the different countries. Any analysis of values and their impact on policy and practice can be problematic, because it involves the challenge not only of eliciting the values which exist but also of determining the extent to which such espoused values are actually used in policy or management. Thus the extent to which potential divergence in health systems is

driven, wholly or in part, by the existence of different values becomes an important but difficult question to address. Accordingly, the Nuffield Trust recently conducted a major investigation of NHS values across the UK and in Europe[7]. The report compared the values embedded in the health services and policies of England, Northern Ireland, Scotland, Wales and the European Union, and identified the challenges posed to UK political institutions by the need to adapt to different national values.

The study concluded that some very different entrenched values did exist, which included commitments to:

- 'collaboration and collectivism' in Scotland
- the very similar 'communication and collectivism' in Wales
- democratic participation, neutrality and the new public health in Northern Ireland: 'having a say rather than having a choice'.

Greer and Rowland describe these values as standing apart from the English preference to markets and technical solutions.

The report argued that understanding shared and differing national values was important in understanding and helping to shape the future of health and devolution. The Trust's work on values forms an important context within which the individual country accounts in Chapters 3 to 5 of this report should be considered.

1.5 Issues beyond the nation state

While political devolution produces challenges from within for the nation state, the latter's role is also challenged by developments at supra-national level. For the UK, predominantly this means developments within the European Union. In 2005, the Nuffield Trust commissioned a detailed analysis of the rapidly developing influence of the European Union in health and its impact on national health systems.[8] The report noted that the development of the EU's role in health had the potential to destabilise all aspects of health policy-making, and recalled the impacts in the UK of the European Working Time Directive, patient mobility decisions, and the increasing number of cases in which the European Court of Justice (ECJ) had applied internal market law to the NHS systems. These combined with a high-profile legislative agenda and the range of existing health-relevant policies to create a serious set of challenges. It argued that these were not one-off challenges but ones which demanded permanent organisational adaptation to a new world of multi-level, Europeanised, devolved health politics. David Hunter[9] asserts that both European health policies and values are at a crucial stage of development.

Particular issues and challenges resulting from EU developments include those facing the UK Department of Health, which has two major functions. The first, which for the UK Government is by far its most politically important one, is as the Department of the English NHS. However, the Department is also the 'federal' department of health for the whole UK and in this latter role was responsible for intergovernmental relations and EU or international affairs in health. For the Department to function effectively as the formal

connection between all of the UK's health systems and the EU required work by both the Department of Health and by the devolved health systems. Thus, European developments present a challenge to devolution itself. There was only one UK voice in Europe, but there were four health systems. Policy might not affect them all equally, but the devolved systems' best chance to influence policy was to influence the UK line, with supplementary activity of their own.

The authors of the report cited above argued that, with time, it became more likely that an EU health issue would become the object of a major intergovernmental clash. They believed that EU health affairs, like every other part of the devolution settlement, would benefit from a dispute resolution system, preferably with a statutory basis, that would allow serious, politically driven disputes to be resolved in some other way than with the simple imposition of the UK government's position.

In response to developing EU health policies, there was scope for a united UK front, animated by commitment to the values of the NHS and resisting the diversion of resources into regulatory compliance rather than the health of the public. Stakeholders and governments were responding along predictable lines and with predictable levels of enthusiasm. There was room for more joint working and involvement in the debate, to avoid duplication, but also preserve and promote the core values of the NHS systems in a diverse and regulatory European Union.

Such is the potential importance of European developments that Section 8 of this report returns to the detail of some of these issues.

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2. THE ROLE OF THIS REPORT

2.1 The purpose of this report

The Nuffield Trust's various initiatives, described above, explore the developing impact of political devolution on the UK's health systems. A phrase in common use at the time political devolution was introduced described it, very appropriately, as a process, not an event.

Most of those involved in the different health systems now recount how the new processes of governance, and the new relationships which came with the new institutions, took time to bed down. There were at least two aspects of this. The Parliament and Assemblies were both new and operated processes very different from those of the Westminster Parliament. And very many of the politicians were new to national-level politics. They, and the government ministers among them in particular, had very steep learning curves. There were very few elected representatives in the new political cadre who had had experience of Westminster politics, even if that had been any preparation for the new world of devolved government. So it took time for all the new machinery to get up to speed. Additionally, the new administrations did not start with blank pieces of paper. Health policy had been run under administrative devolution prior to the introduction of political devolution. Because of this, the Parliament and Assemblies inherited existing policies, and an amount of work in progress. For all these reasons, the account in the 2003 report could not be a final assessment of the impact of devolution in health. The process has continued to unfold over the past four years.

The primary aim of this report, then, is to update the devolution in health story by producing a brief account of key developments over the last four years in the three devolved administrations, and present a snapshot of where things stood in the spring of 2007. This account is modelled on the 2003 report, which itself was written as one of a series. In the current case, however, an attempt has been made to produce an account that is as self-contained as possible, for the benefit of those who are not familiar with the previous reports. In common with the other reports, much of this account is descriptive and historical. Perhaps the only prediction that can be made with complete confidence is that parts of it will be out of date and incorrect in some significant way by the time it is published! This is because of the unfolding pattern of events following the 2007 elections in the UK's devolved administrations and the change from the Blair to the Brown

government. Like any snapshot of a fast-moving subject, there is a danger that parts will be blurred and out of focus.

2.2 The UK's family of health services?

As noted above, some differences between the health systems in the four member countries of the United Kingdom predated political devolution. However, since devolution other, significant, differences had developed in the systems of accountability, organisation and management of the four health systems. There was no evidence that any of the UK administrations was anything but fully committed to the fundamental values and principles of the National Health Service (a health service accessible by all, free at the point of delivery, and funded by general taxation). However, given the developments since devolution, it was now more appropriate to speak of the UK's 'family of health services' than a single UK-wide 'National Health Service'.

In 2003[1] Jervis and Plowden argued that, in general, there were more similarities between the governance and accountability arrangements for health adopted by the administrations in Northern Ireland, Scotland and Wales than there were between any one of those administrations and England. Many of the policies and approaches in Northern Ireland, Scotland and Wales increasingly seemed to be diverging from those adopted in England. Yet it was too soon to say whether, in terms of health outcomes, any of these approaches were 'better' or 'worse' than any of the others.

The most obvious changes noted in the three smaller countries of the UK had 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 were 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 were strikingly different from those in Westminster in terms of openness, inclusiveness and transparency.

It was argued that these changes increased both the pressures and the scope for political intervention. They affected, not always for the better, the systems' capacity for strategic planning and for 'joined-up' policy-making.

Jervis and Plowden also commented that the influence of the European Union in health policy had increased rapidly in the past three years and the process seemed likely to accelerate. In future, they argued, the European dimension was going to figure much larger in the formulation of health policies within the UK. This might well pose greater challenges for the UK policy machinery, and for intergovernmental relations. They believed that those responsible for the UK family of health services did not yet appear to have fully recognised the potential significance of European developments. The possibility existed that European policy would force more similarity, for instance in funding levels or

mechanisms, individuals' rights to treatment, the 'rationing' of expensive treatments, and so forth. The UK Health Department would need to evolve to to address such developments.

Jervis and Plowden then looked forward and posed a number of questions about future developments. Among other things, they asked:

- Would 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 across the UK widen the health policy gap between the countries, and could this generate tensions in intergovernmental 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 citizens' satisfaction with health status and health services?
- Would experimentation with a 'mixed economy' of provision of English healthcare lead to pressure on the devolved administrations for similar experimentation?
- Would developments in regional devolution in England lead to further pressures on the English NHS to become more accountable locally or regionally?
- Would the Welsh Assembly wish to increase further the distance between England and Wales in terms of both policy and practice? If so, will the Assembly wish to argue that it should have legislative powers equivalent to those of the Scottish Parliament?
- Would 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?

Writing in 2007, it is interesting to note that many of these questions are still important but cannot yet be answered with any degree of confidence. The sections that follow attempt to provide some answers, but also identify some new questions, the answers to which lie in the future.

A secondary objective of this report is to test the conclusions of both the original 1998 report by Hazell and Jervis and the 2003 report by Jervis and Plowden. In particular:

- Is it still appropriate to talk of the UK's 'family of health systems' rather than the UK NHS?
- Are the different health systems continuing to diverge from each other, or are there pressures which will lead in time to a re-convergence?
- What are the implications of current developments both for citizens and for those with responsibility for health and health services policies?

2.3 A note on Northern Ireland

The first report on Devolution and Health[2] was based on research in England, Scotland and Wales. The subsequent monitoring exercise attempted to track developments in all four UK countries, including Northern Ireland, and had reported on them at intervals. But by the time the 2003 report was written, political devolution had been suspended and the Province's health services were once again being run under direct rule from Westminster.

That situation has continued virtually until the date of preparation of this report, with devolved government only being re-established in May 2007. Because of this, much of the evidence to date about the effects of devolution on health has to be based on developments in Scotland and Wales only. The section on Northern Ireland attempts to provide a brief account of health policy and related developments in the Province over the period 2003 to 2007, introduced under direct rule from Westminster. It remains to be seen how much of the health policy legacy from this period will be endorsed by the new devolved administration.

2.4 The structure of this report and methodology

Chapters 3, 4 and 5 contain accounts of the development of the health systems of Northern Ireland, Scotland and Wales respectively. Each country section starts with a brief resumé of the situation as described in the 2003 report. There is then a discussion of the key policy initiatives taken in health and health services in the period from 2003 to 2006. This factual information is included partly because many readers may not know the details of policies in administrations other than their own, and partly to make this report more self-contained. The policy synopses are followed with a more subjective reflection on the development of the respective health systems as revealed by interviews with senior executives and civil servants. Where possible the 'inside' views of the different health systems are then compared with general survey information. Finally, there is a brief discussion of the role of health in the 2007 election campaigns in Northern Ireland, Scotland and Wales and some brief details of the early steps taken by the incoming governments.

Chapter 6 contains a short discussion of developments in England, and of the evolution of UK-level policy. This chapter is shorter than the equivalent one in the 2003 report, largely because the expected further development of the political devolution agenda within England has not materialised to date.

Approaches to health systems cannot be viewed in isolation from the more general policies towards public services adopted by the different administrations. In the period covered here, all the administrations have reviewed and developed their approaches to public services. Accordingly, Chapter 7 compares and contrasts these approaches. As predicted in the 2003 report, and as discussed above, European health policy developments have accelerated and now raise many issues for the UK's family of health services. Chapter 8 addresses these developments in more detail. Finally, Chapter 9 offers some conclusions and reflections on devolution in health in 2007.

The methodology used to produce this account mirrors that which was used to produce Hazell and Jervis' *Devolution and Health* report in 1998. It draws on interviews conducted in Northern Ireland, Scotland, Wales and (to a lesser extent) England, official publications, media reporting, and discussions at various seminars and meetings. Those interviewed included senior civil servants, health service managers, representatives of Royal Colleges and similar organisations, and senior academics.

The fieldwork on which this account is based was carried out between November 2006 and April 2007. All the fieldwork in Scotland and Wales took place before the national elections of May 2007, while that in Northern Ireland spanned the period of the Province's election campaign in March 2007, though it was completed before the final political agreement to restore devolution. Publication of this report has been timed to allow it to reflect the 2007 election campaigns, their outcomes and the very early steps taken by the new administrations.

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3. NORTHERN IRELAND

3.1 Looking back

Jervis and Plowden's 2003 report[1] contained a précis of the quarterly monitoring reports submitted by the Constitution Unit's Northern Ireland monitoring partners. In their opinion, the early stages of devolved government had been marked by the general absence of preparedness of all ministers after the long decades of 'opposition' under direct rule. They cited a former public health official who had spoken of a 'policy deficit' on the part of the political parties, and they referred to the difficulties faced by the Health Secretary in the devolved administration. The Belfast agreement nominally had ascribed to the Northern Ireland Assembly a powerful system for bringing the Executive Committee to account, via its statutory committees, shadowing each of the ten departments. However, the monitoring partners reported that the Executive Committee has been the dominant partner in its relationship with the Assembly for a number of (unintended) reasons.

First, the 'inclusive' nature of the Executive, in which all four major parties were allocated ministries via the use of the D'Hondt system[i], had left (apart from the fringe parties) only the five-member Alliance party as a significant opposition in the Assembly. Not only did this mean that there was no sense of a 'government-in-waiting' should the Executive become unpopular, it also meant that every committee of the Assembly included an overwhelming majority of members from executive parties. The health committee had, however, flexed its muscles against the minister on one occasion. Where legislation was at stake, the minister had to secure the support of an assembly majority and was therefore vulnerable to committee-stage amendments. This was the fate of the Health and Personal Social Services Bill, abolishing GP fundholding. In general, the monitoring partners felt that the ethos and practice of partnership that could animate the department–committee relationship appeared to have foundered in the case of health.

There was also a comment about the difficulty of facing unpopular decisions. Elected representatives had, if anything, been too responsive to their electorate and therefore had been unwilling to show leadership in tackling difficult decisions. The report noted that successive social attitudes surveys had consistently given pride of place to health as the

i The D'Hondt system is a form of proportional representation named after its originator, a Belgian lawyer and mathematician.

key intended beneficiary of increased public spending, and that any debate about rationing had been absent. The instinct of Members of the Legislative Assembly (MLAs) had been to support all services being retained at all acute hospitals – the one in their constituency, at least – even when that had a negative effect on standards of treatment overall. Assembly members had not had to confront the hard decisions associated with priority-setting and resource allocation. The different worlds inhabited by Northern Ireland's political class, on the one hand, and health service managers and practitioners on the other, tended to engender frustration on the part of the latter with regard to the former.

The monitoring partners felt that the depth of the crisis in the health service was not being fully appreciated by the politicians and the need for urgency was not being recognised. Two areas of concern had proved particularly difficult during devolved government: primary care structures and secondary acute provision. Both of these had been the subject of extensive elaboration and consultation under direct rule, premised on the assumption that the new minister would move forward rapidly. This had not been the case, with further delay caused by more consultation.

Mention was made of the then Chief Medical Officer's hard-hitting annual reports highlighting Northern Ireland's disturbing indices of mortality and morbidity, and growing inequalities in well-being. These had stressed that the causes and solutions to many of the major health problems in Northern Ireland lay outside the areas traditionally dealt with by the health services in areas such as poverty, unemployment, education, the environment and social exclusion, and had argued for partnership working between government, other agencies, organisations and individuals.

As they looked ahead in 2002, the monitoring partners identified a deepening crisis of the system as demand outstripped supply in the hospitals. They noted the Health Minister's undoubted case for additional funding, even though she came into office against a background of per capita expenditure on health and social services higher than in any English region and higher than in Wales, if lower than in Scotland. Health subsequently had done better in funding terms than any other devolved department. The final comment was that tackling all the problems identified required a government wedded to collective responsibility and an Assembly with the capacity to bring the executive to account.[2] In the monitoring partners' view, the Belfast agreement had delivered neither, and had bequeathed to Northern Ireland a system of governance which they could only describe as unhealthy.

By the time the final monitoring report was delivered the Assembly had once again been suspended and direct rule recommenced. Considerable health challenges remained to be addressed.

3.2 Northern Ireland's health policy – the key building blocks

Although the monitoring reports revealed the difficulties of facing up to difficult decisions about service reconfiguration, the previous power-sharing Executive of 2002 did finally

address the future pattern of hospital services for the whole of Northern Ireland. Recognising the need to maintain the balance between accessibility and sustainability, the result was a strategic approach to the provision of hospital services across Northern Ireland. During the period 2002 to 2007, work has continued to implement this strategy.

3.2.1 The Review of Public Administration and its recommendations for health and social care

One of the major policy initiatives during the period 2002 to 2007 was the Review of Public Administration. This was not specific to health. It was a comprehensive examination of the arrangements for the administration and delivery of public services in Northern Ireland and covered over 150 bodies, including the 26 district councils, the Health and Social Services (HSS) boards and trusts, the five Education and Library Boards and about 100 other public bodies. The main Review is discussed further in Section 3.3, and it formed an important part of the backdrop for all else that happened in health and health services during the period.

The specific recommendations for health, which formed part of the consultation document published in March 2005, suggested an optimal configuration of five new Health and Personal Social Services (HPSS) agencies. The main elements of the proposed new HPSS structures were:

- The DHSSPS would remain responsible for determining regional policy and strategy, legislation, allocation of resources, setting targets, performance management, and oversight and management of HPSS bodies.
- The current four HSS Boards and 18 of the 19 HSS trusts would be replaced by five (or seven) new HPSS agencies. Their functions would be to assess the needs of their populations, commission services, and to provide directly or secure the provision of such services, in partnership with the independent sector, as appropriate.
- A Regional Forum consisting of the chief executives of the HPSS agencies and the regional service delivery body, and chaired by the Permanent Secretary of the DHSSPS, would advise on the development of regional services and the work of the agencies;
- The existing Regional Service bodies would be reduced from six to four or five:
  - The Central Services Agency (CSA)
  - The Health Promotion Agency
  - The Blood Transfusion Agency
  - The Northern Ireland Ambulance Service
  - The Guardian Ad Litem Service (depending upon the outcome of a separate review).

The Review described its proposals as the most significant change in the management of health and social services in Northern Ireland since the creation of the internal market at the beginning of the 1990s. Implementing these changes, while maintaining a focus on the delivery of services and continuing to improve them, would be a formidable challenge. It would therefore be essential to ensure that continuity could be maintained during the change programme. Very importantly, the Review's proposals for health and social care

were to be altered after the first public consultation in one extremely significant way, as is discussed in the next section.

3.2.2 *The Independent Review of Health and Social Care Services in Northern Ireland* (The Appleby Report)

In 2002 and 2003 Derek Wanless carried out for the Chancellor of the Exchequer his independent review of the long-term resource requirements for the NHS in England, and then conducted a similar review in Wales. In December 2004 the Minister for the Department of Finance and Personnel in Northern Ireland commissioned a similar independent health review which was carried out by Professor John Appleby. His report addressed three main areas:

- funding
- use of resources
- performance management.[3]

The report concluded that the Northern Ireland health and social care sector did not appear to have been significantly under-resourced previously, but looking forward it would come under increasing pressure to replicate the improvements in health outcomes envisaged for the UK by Sir Derek Wanless. Appleby commented that:

> *It is clear that a significant underlying reason for current problems with the Northern Ireland health & social care sector relate to the use of resources rather than the amount of resources available.* (p. 13)

There was considerable scope for improvement in the provision of services, conditional on appropriate incentive structures being in place that focus on improving health outcomes, while recognising that more efficient delivery means more resources available for service improvements.

Appleby noted a real openness for reform which he said, although evident in some specific areas, was not being driven forward on a widespread basis. He echoed the earlier comments of the Nuffield Trust's monitoring partners when he commented:

> *The general perception was that political instability and a lack of leadership throughout the system had created an unstable environment where it took too long for decisions to be made and which in turn were too easily obstructed from being implemented by narrow local concerns.* (p. 3)

A particular area of concern he mentioned was the lack of progress on waiting times despite significant additional resources.

Appleby observed that, in common with the rest of the UK, significant additional resources had been devoted to the provision of health and social care in Northern Ireland in recent years. But the short-term and uncertain basis on which funds had often been allocated had hampered the strategic planning of services. Around three-fifths of the additional funding had been absorbed by increases in staff costs, although most of this

had been in higher wages and salaries rather than more frontline staff. Around a quarter of the additional funds had been spent on service delivery improvements, but cost pressures would mean that a much smaller share of future funds would be available for service improvements. He also noted that, in common with the rest of the UK, labour productivity in the health and social care sector appeared to have fallen since 1998/99.

Appleby's report made 25 recommendations in all. He made a number of recommendations about financial management and budgeting. In particular he placed a strong emphasis on outcomes: "The main performance policy monitoring focus should be on tracking outcomes, not spending per se" (p. 34). He noted the financial pressures on Northern Ireland's health and social care services. Northern Ireland was currently funded on the basis of its population share of increases in spend in England by the operation of the Barnett Formula. However, this mechanism did not take into account the differences in the need for health and social care expenditure between Northern Ireland and England. Appleby's judgement was that a reasonable need differential between England and Northern Ireland should be around 7%. Expenditure projections based on a 7% higher level of need suggested that a significant increase in resources was required in the coming years.

A key issue was whether the greater level of spending should come from other spending areas within Northern Ireland or from additional allocations from HM Treasury. Given that health and social care accounted for over 40% of Government spending in Northern Ireland, and the likelihood that other areas of spend in Northern Ireland would have a higher need than in England, Appleby argued that it would be unsustainable for the additional resources to be entirely sourced from within Northern Ireland.

A major thrust of the Appleby Report was the critical importance of using available resources as efficiently as possible. Although overall, health status in Northern Ireland was *slightly* worse than in the rest of the UK, there appeared to be a number of areas where health care utilisation was *substantially* higher than health status would suggest. For example, accident and emergency attendances were almost a third higher than in England. To achieve the Wanless 'fully engaged' scenario implied that considerable effort would be needed to engage the Northern Ireland population through expanded public health services and other means.

On a whole range of performance indicators, the review found differences with England.

- Hospital activity per member of staff was 19% lower than the UK average.
- Hospital activity per £1 of health spend was 9% lower than the UK average.
- Hospital activity per available bed was 26% lower than in England.
- The unit cost of procedures was 9% higher than in England with day case unit costs 9% lower and elective inpatient unit costs 12.6% higher.
- Average unit prescribing costs were nearly 30% higher.

These differences prompted Appleby to comment that:

> *Overall, the picture that emerges is one of fewer outputs achieved per given level of input than in England, although some aspects of poor performance are shared with Scotland and Wales.* (p. 8)

One of the most obvious indications of poor performance was the large number of people on waiting lists and waiting times for treatment compared with the rest of the UK. Appleby's survey of GPs indicated that one of the main perceptions for the lack of progress in this area was

> *the lack of a consistent commitment throughout the health & social care system to reducing waiting times, as well as the lack of incentives or sanctions in order to drive the effort to meet the targets.* (p. 7)

He concluded that solutions to the problem required a 'whole-system' perspective, with consistent commitment from the highest levels of management.

Although GP list sizes were smaller in Northern Ireland, the number of consultations per head of population was higher. There appeared to be a lack of integration between GPs and the rest of the primary care sector which needed to be improved through a change in attitude on both sides. Appleby noted that:

> *Northern Ireland still appears to be many years behind in England in terms of achieving the policy aim of providing social services in a community rather than hospital environment wherever possible.* (p. 56)

Appleby repeatedly stressed the critical importance of effective performance management arrangements to drive the system forward to improve efficiency, effectiveness and responsiveness. Current performance management arrangements, he said, lacked appropriate performance structures, information, and clear and effective incentives at individual, local and Northern Ireland organisational levels to encourage innovation and change.

Interestingly, and possibly to some people's surprise, Appleby also commented at length and critically on the Review of Public Administration's recommendations for reconfiguring health and social care organisations. He described the creation of five (or seven) Health and Personal Social Services agencies as in effect reinventing a pre-1990 English NHS model in which health authorities received weighted capitation allocations, planned services and directly managed (and set budgets for) the hospital providers in their area. He commented that in this model it was not clear how performance improvements were actually to be achieved. In particular, it remained to be seen how providers were to be held to account for their performance.

> *There is a distinct danger that the performance model implied by the RPA's structural reform could fail to provide the necessary incentives and sanctions – or 'bite' – to encourage providers of services to continually seek out new ways to improve their performance.* (p. 171)

Appleby argued that, from the point of view of performance management, it was hard to see any difference between the RPA's recommendations and the way the current system operated. He therefore proposed an alternative model, with some form of separation between the providers of services and the funders/commissioners of services. This would be an important factor in sharpening up incentives in the system.

> *While the four health boards have, in theory, acted as commissioner/purchasers, it is not clear that the full benefits of this arrangement have been achieved. It may be that a single pan-Northern Ireland commissioner would be more appropriate.* (p. 171)

Appleby made many more suggestions about performance management, mostly based on the approaches which had been adopted, successfully he argued, in the English NHS. He recognised the differences with England, saying that the nature of the rewards and sanctions needed careful thought:

> *The competitive economic environment – at least as it is currently being developed in England – is unlikely to be appropriate in Northern Ireland. However, this does not rule out, for example, the introduction of an activity-based prospective reimbursement system for providers (similar to Payment by Results) with tariff-setting (not necessarily fixed at average costs) used to drive improvements in efficiency and selective increases in activity to meet pan-service goals.* (p. 11)

He argued that, despite the previous rejection of GP fundholding, ways of obtaining the practical involvement of GPs in the purchasing of care should be investigated. Appleby argued that there was a need to develop an explicit performance management system with rewards and sanctions which provide enough 'bite' to encourage change and innovation in the health and social care system. This should include a separation of the tasks of service provision and commissioning (including the establishment of a pan-Northern Ireland commissioning body) to 'sharpen' incentives. There was also a need, alongside the performance management system, to explore the development of a more transparent priority-setting process at national level, together with an explicit 'NHS Plan for Northern Ireland' which set out outcome-based targets linked to new spending paths.

The then Health Minister Shaun Woodward welcomed the Appleby Review as a timely and extremely important contribution to the development of health services. He said:

> *Too many people have had to tolerate unacceptable levels of services for too long. The performance of these services needs to be improved across a range of areas and this report sets a challenge to the health service to make those improvements a reality. It demonstrates that there is much more we can be doing with the resources we have.*[4]

The Minister accepted the recommendations on the more efficient use of resources and the need to improve performance management, and intended to develop an action plan to ensure that the recommendations were implemented as quickly as possible. He also committed to receiving the views of the public on Appleby's recommendations about future health structures, as part of the Government's ongoing consultation on the Review of Public Administration. The final proposals on health and social care service configuration included a single pan-Northern Ireland body recommended by Appleby. The new Health and Social Services Authority was to replace the four existing Health and Social Services Boards and would be responsible for promoting public health and for ensuring that the health and personal social services sector performed efficiently, effectively and economically.

3.2.3 Sperrin Lakeland – tackling unsafe services

This chapter concentrates on major all-Northern Ireland policy initiatives, and therefore does not deal in detail with the many individual reconfiguration issues the services have addressed. One exception is being made, because of the wider significance of the issues involved, and the impacts these had on those involved with the Northern Ireland health services. This involves the actions the then Health Minister Shaun Woodward took in connection with the Sperrin Lakeland Trust.

An Ulster television programme in October 2004, the result of several months of investigation, claimed to have produced evidence of how the Sperrin Lakeland Trust had covered up a child's death caused by the hospital's incorrect treatment. The programme claimed that the management at the Sperrin Lakeland Trust had covered up the fact that the Erne Hospital caused the death and also that doctors at the Royal Belfast Hospital for Sick Children had misled the Coroner into believing that the child's death was due to natural causes.5 In November 2004 the then Health Minister Angela Smith established an independent inquiry into the deaths of three children, one being the child featured in the television programme.6

In addition, reports on patient safety were commissioned from the Royal College of Surgeons, the English NHS Clinical Governance Support Team (CGST) and from the Sperrin Lakeland Trust itself. These reports were strongly critical of the operation of the services. The CGST report found "significant gaps in risk management at all levels", and criticised the Trust's governance arrangements, finding a "lack of clarity regarding organisational accountability, responsibility and decision-making in the trust". It stated that investigators had heard of a "considerable number" of examples of where adverse clinical incidents had occurred and although staff had reported them formally and informally, there had been little or no feedback and "nothing had been done about the incident". The review team condemned the Trust's management and said: "There is a capacity and capability gap in the leading, planning and managing of change within the organisation."

The publication of the report led to the immediate resignation of the Trust's chief executive,7 the first time a chief executive in Northern Ireland had been removed on the grounds of patient safety. The Health Minister stated that he was deeply disturbed about the conclusions of the report and said: "The very serious criticisms of risk management must be addressed as a priority to ensure public confidence is maintained in the trust." These developments, and the vigorous way the Health Minister stressed patient safety matters, gave added impetus to the need for service reconfiguration.

3.2.4 Implementation

A consultation on the Review of Public Administration's proposals for trust reconfiguration took place early in 2006. In summer the chairs, non-executive directors and chief executives were appointed and in the autumn trust management structures were developed and the trusts began shadow running. The new trusts formally became

operational on 1 April 2007. Work proceeded on the establishment of the new commissioning system and the establishment of the proposed seven Local Commissioning Groups.

3.3 The view from the Northern Irish NHS

3.3.1 Introduction

Whereas in Scotland there seemed a considerable amount of consensus between the people interviewed, there was more diversity in the views in the Province. In general, people considered that some progress had been made over recent years, but not enough. There was guarded optimism that many of the building blocks had been put in place which had the potential to allow the health services to move forward, but a certain amount of trepidation remained about what the resumption of devolved government might mean for the ability to tackle some of the difficult decisions that were needed.

Time and time again respondents referred to the very small population of 1.7 million people, and the fact that health services have to be reformed and reorganised. But this did not just mean wholesale hospital closures and rationalisation of services. It was stressed repeatedly that innovative approaches were needed to provide services in a way appropriate to local conditions, not the importation of unchanged models that had worked elsewhere.

3.3.2 The resumption of devolved government

There were concerns about factors that might be shaping the future in an inappropriate way. One was the approach which had been taken in recent years by direct rule ministers, and particularly the Northern Ireland Secretary, thought to be carefully agreed with 10 Downing Street. This strategy consisted of imposing on Northern Ireland policies and decisions which were deeply unpopular with the public, such as water charges and rating changes, and in effect saying to them "If you don't like what we decide, agree to resume governing yourselves".[8]

While this strategy might have been instrumental in finally forcing the leader of the Democratic Unionist Party (DUP), Ian Paisley, to accept power-sharing with Sinn Féin, it might also leave the impression that the resumed devolved administration could avoid unpleasant decisions and reject policies and strategies adopted by direct rule ministers. (The resumption of devolved government meant that the proposal for water charges was withdrawn.) There might be moves to overturn other policy changes, which might be harder and have consequences which were more difficult to accommodate. Looking back to the previous period of devolved government, respondents commented on the lack of cabinet responsibility for Executive decisions, and the difficulty of obtaining support for unpopular decisions. The run-up to the resumption of devolution had done little to convince people that things would be much different this time. People found it easy to imagine that unpopular hospital service reconfiguration decisions could also be challenged, overturned or delayed.

Politicians' attitudes to the Review of Public Administration were seen to be particularly important. Much had already been done to implement the Review's recommendations, yet four of the five parties making up the Executive did not support the seven-council model for local government. The health services had already aligned their structures with the new local government structure which they expected to be introduced. In general, people felt that it would be relatively easy to accommodate any local government changes by redrawing the boundaries of Local Commissioning Groups, maintaining co-terminosity, which was agreed to be essential. The establishment of the new Health and Social Services Aunthority (HSSA) to operate between the Health Department and the services was felt to be more controversial in some political quarters. People were not expecting its role or existence to be challenged, but many respondents saw potential for tensions over its operation.

3.3.3 English solutions for Irish problems?

The recent history of Northern Ireland's governance has been shaped by direct rule from Westminster and the actions of direct rule ministers. The short lifetime of the previous devolved administration was a relatively brief interlude in a quarter of a century of Westminster rule. As a result, in the words of one respondent: "For 25 years relatively little happened in Northern Ireland other than a rebadging of English policy."

Although this happened, enforcement of Westminster policies was not necessarily pursued too energetically. Another comment was that Northern Ireland received a 'bye' or exemption from many policy initiatives. When government came from England, people perceived that usually there was not the same ideological drive, nor did the issues seem to matter so much to ministers. As a consequence Northern Ireland had been in a "funny sort of limbo". There were two notable exceptions to this general pattern. One was the then Secretary of State, who was seen as pushing a strong ideological line as part of the UK government strategy to encourage a resumption of devolved government, the other was Shaun Woodward during his time as health minister.

There was therefore a paradox about Northern Irish policy. While most of the key decisions that were shaping the future of the Northern Irish health and social care system were being developed or taken by direct rule ministers, they actually had more freedom to take difficult or unpopular decisions, but often appeared less interested in doing so. The main approach, in the words of another interviewee, was that: "when Northern Ireland needs a policy, the default position has been to borrow from England, with adjustments where necessary". Northern Ireland's recent waiting-list initiatives were cited as an example of approaches borrowed from the English.

This adoption of English approaches was seen to be particularly true of the most recent proposals for the health service reorganisation. The current ideology was about a commissioner/provider split to drive performance improvement and efficiency, although using a different kind of market mechanism from that in England. The choice of Professor Appleby to carry out the independent review of health and social care had resulted in

particularly significant changes. Respondents noted that commenting on the five- or seven-health board model was not expected to be part of his remit. However, his argument that Northern Ireland needed a commissioning and providing dynamic had convinced the minister that a 'strategic health authority model' would be more robust, and this had become part of the final RPA (Review of Public Administration) decision. It was felt that there would have been support in Northern Ireland for an organisational model more on the lines of the one used by Scotland, but Woodward was seen to have been a key influence in persuading the RPA to introduce separation between the Health Department and the health service.

There was a general recognition, both within the health and social care communities and by the politicians, that the status quo was not an option. Northern Ireland had a population of 1.7 million people, 50% of whom lived in rural communities. It was described as, in effect, a relatively closed system. In Northern Ireland there were no major independent players. The introduction of independent sector treatment centres, as adopted in England, was thought likely to damage other providers and destabilise the system. Therefore some did not support the idea of an English model of an internal market and a tariff, even if it was accepted that the tariff should be different from the English one. Others argued that an approach based on leadership, central planning, direction and performance management would better fit the requirements of the Province.

Respondents noted the degree of change and innovation already being undertaken. With the benefits of a system that included both health and social care, the new approaches to service delivery would cut across existing institutions, and include both primary and secondary care. There were, it was argued, no organisational models elsewhere that could be used: "You cannot say that just because you have chosen to live in the rural world you have to travel for help." Northern Ireland had to generate new solutions appropriate to its needs, and was in the process of doing so. But were those who thought that even more radical models needed to be identified, and the 'English solution' might inhibit this. There was a chance for Northern Ireland, if it grasped it, to become a European exemplar among smaller countries.

3.3.4 Service reconfiguration – implementing the Developing Better Services strategy

Despite the early difficulties, during the first period of devolved administration, in getting decisions both made and supported politically, a plan for the future profile of hospital services was published by the former Sinn Féin Health Minister Bairbre de Brun in June 2002. This had continued to provide the template for reform and reorganisation. A considerable degree of progress has been made, although performance has differed across the different health board areas.

Much of the agenda had been addressed through a gradual process of hospital service reconfiguration. The Eastern Board, for example, had made significant progress in rationalising the number of sites providing maternity services. The number of emergency

surgery providers had been reduced, and the profiles of ambulatory, elective and day surgery had been raised. There had been closures of some accident and emergency departments and a major primary care programme had been developed. Although developments in other Health Board areas had progressed rather more slowly, nevertheless, waiting lists had been reduced and services were improving. All of this had been achieved in an interim period with English ministers.

Much remained to be done. For example, current Royal College standards suggested that Northern Ireland should have only three acute hospitals. The Developing Better Services strategy talked of a reduction to nine (and this change had not yet been implemented). Currently Northern Ireland had about twice as many hospitals as a comparable area in England, and was increasingly looking old-fashioned by comparison. Some argued that the reason the RPA's proposals gained political support was because of the unpopularity of what was seen as NHS bureaucracy and management. Many of the changes impacted mainly on management structures, with only about one-third of the existing senior executives staying in the service. Therefore they had not been resisted by local politicians. However, the politicians had not worked out all the impacts of their changed relationships with local providers. And there was no confidence that difficult decisions would continue to be supported when devolved government resumed.

3.3.5 North–South issues

Northern Ireland is unique among the four countries of the UK in that it has a land border with another Member State of the European Union. In this respect, the European Commission's consultation on patient mobility is perhaps of more immediate relevance to the Province than to the other administrations.

Despite obvious political tensions, there were many examples of practical cooperation between Northern Ireland and Eire, and these were thought likely to increase. For many, North–South health cooperation was an idea whose time had come. One key driver for this, it was argued, was that many of the problems that Northern Ireland's health services faced were matched by similar or even greater problems in the Republic. There was already cooperation in the border areas with, for example, out-of-hours cover for people in Donegal being provided from Londonderry, and cooperation over specialist services. There were a number of all-Ireland bodies, including a cancer network that was benefiting from US sponsorship and funding. To some extent, the health services tended to be searching out opportunities for collaboration, and challenging the political systems.

The politicians had different views, depending on their party. The St Andrews agreement that re-started the process leading to devolved administration included arrangements for North–South ministerial meetings. But the Democratic Unionist Party (the party with the most seats in the Assembly at that time) had argued that any North and South bodies had to be made more accountable, with accountability lying with the Assembly. Senior civil servants from the two countries did meet fairly frequently, and had

identified areas where they might collaborate. But collaboration is a political decision, so it has to wait for political leadership. As one respondent commented: "The civil servants don't start hares running, because it is still a divided country." Nevertheless, together, Northern Ireland and the Republic presented a relatively stable population which has advantages, for example, in drug trials for cancer services. There was also a relatively stable workforce, but with opportunities for people to cross the borders. There was scope for emergency responses to events like the Omagh bombing, and special arrangements for cross-border relief nurses. There were problems, however, about how to put this on a more formal footing, as it would require legislation in both the UK and the Republic.

There were a number of differences between the two health systems. The structures were different, as were the power relationships between consultants and others in the system, with the Republic being described as having a very strong medical lobby. There was also a separation of community care from hospital care in the South. The Republic was noted to be much more open to the market economy, and also had been pursuing a policy of co-development of public and private provision. As a result of these different trends, the two healthcare systems were fundamentally different. In general terms, the Republic was seen to be facing similar or even greater healthcare problems and challenges than the Province, and this was a driver for more North–South collaboration. Respondents claimed that Northern Ireland was delivering better, cheaper, healthcare than the Republic, noting that the All-Ireland public health organisation had shown a 'health gradient' between the two countries. They claimed that, in a number of ways, the Republic's health system was further behind than that of Northern Ireland.

To many in health, the different systems were not seen as a great impediment to cooperation. The political view might have been somewhat different. For example, although Sinn Féin was committed to reunification, it did not share some of the Republic's ideas about commissioning and choice in healthcare, and did not support the incorporation of those ideas in the establishment of the North's new HSSA. Because of the common land border, the UK responses to any EU consultations on health services were seen as particularly important for Northern Ireland.

3.3.6 Governance and accountability

It was reported that there was a degree of political consensus around the agreement to reduce the number of trusts. The move from the current health boards to the new HSSA was something for which the senior civil service was said to have lobbied strongly, and was thought to have general support in the new Assembly. However, the Sinn Féin election manifesto made it clear that they had no interest in a commissioner–provider split, and more generally many people in Northern Ireland were not comfortable with the idea of a market place in health. Supporters of the new organisational model argued that it was possible to use commissioning as a strategy even with a very small independent sector, and noted that a number of parties in the Executive would be sympathetic to the use of contestability.

Sinn Féin were expected to argue that health boards should be democratised and would want to involve in them people from all walks of life. Many spoke with approval of their Investing for Health[ii] strategy.[9] In the previous period of devolved administration, the D'Hondt arrangements had made difficult the exercise of Executive and Cabinet responsibility or corporacy. There had been tension between the health minister and the chair of the health committee, who the system required came from a different party. There was a concern whether in the new system the HSSA would be used as a protection by the minister.

One point of tension was expected to be between the Health Department and the new commissioning organisation. Several people argued that one-on-one accountability arrangements did not work well, and that some of the parties, particularly Sinn Féin, would not like the separation between the government and the service. As one commented: "Issues in health and social services will not get politicians elected but can get them de-elected."

3.3.7 Accountability and the media

Currently, the media were being extremely active in health issues, and raising major issues about accountability in government. Respondents commented that for a long time the local media did not cover health in any detail, largely because other topics were judged more important. There was little specific expertise, resulting in a lack of coherence in approach and, in the main, the featuring of English stories. This had recently changed, and the media currently had a controversial role. Major service failings were getting publicised, but not in what most respondents felt was a balanced way. Much of the coverage was motivated by the inequalities agenda, and there was a predominance of negative stories about poor and unsafe services.

One particular personality in the media was considered by many to be largely responsible for much of the current coverage; This journalist's approach was often characterised as deliberately provocative. During one of my visits, he had been running a story on learning disabilities. The storyline was about pressure to close down institutional care, but where the build-up of services in the community had been too slow. Although only one particular case, this story illustrated the problems that lack of balance could cause. Cases of abuse had been claimed, and the media were now bringing pressure to close one long-stay facility. However, there was not enough money to maintain the patients concerned in the community, and these included voluntary patients staying alongside those who had been confined. The programme had picked up the issue, and there had been a Freedom of Information request from the mainland BBC about patients in wards.

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ii The Investing for Health strategy was launched in March 2002, setting out how the Northern Ireland Executive planned to achieve its aim 'to work for a healthier people' – one of its overarching priorities. The report was a cross-departmental, multi-sectoral framework for action to improve health and wellbeing and reduce health inequalities in Northern Ireland.

All the exposure had led to an additional expenditure by the health board of £1 million, which clinicians and managers reported brought little or no gain. More importantly, clinicians were said to have been reporting that some of the patients in the long-stay facility had been so unsettled by the uncertainty generated by talk about its closure that their behaviour had regressed. This was felt to be a direct result of the programme's interventions. The issue had been a top news item for three days. As if to illustrate the respondents' point, on the radio at 9am on the day of my visit, the journalist had demanded that the Health Department produce a statement on the issue, and one had been published 90 minutes later. Several respondents were extremely critical of the programme's approach, and what they perceived as the license given to the presenter by the BBC. It was suggested that he was so popular with his audience that the local BBC management found it difficult to stand up to him. The criticism was not of the stories as such, but of the editorial control – or lack of it – which meant that complex issues were not being covered in a balanced manner. The programme schedule of local radio contained a number of other phone-in and news programmes, the result being that, in one respondent's words "the media is in your face the whole day".

One of the consequences of the media giving health so much attention was that most trusts now had their own public relations offices; the (large) Belfast trust was said to have about half a dozen communications staff. With the resumption of devolution, and perhaps a new focus to the stories on which the media would concentrate, respondents predicted that scrutiny and controversy over health and social care service issues would increase.

3.3.8 Finance and resources

All the political parties in Northern Ireland were promising to spend more on health, and although there were significant fiscal differences between them the Assembly was considered likely to be more sympathetic to increasing health spending than had been the direct rule ministerial team. A prediction was that the incoming finance health minister would be likely to favour economic development over public services, in an administration which was expected to have a 'soft liberal' tone. It was argued that the Barnett formula worked against Northern Ireland. Whereas previously it delivered considerably more per capita than for England, the level had now fallen below Scotland and Wales, although still ahead of England. The forthcoming comprehensive spending review was looking very challenging, although the current position showed 'admirable' financial stability, with all trusts in balance. Respondents echoed Appleby's remarks that the proportion of the Northern Ireland block grant allocated to health was so large that it was hard to increase it without decimating other budgets. "The prediction of seven fat years followed by seven lean years looks pretty accurate."

The new trust structure was thought likely to increase the risks involved in managing the health and social care budget. One of the new trusts, Belfast, dominated the picture. It would employ around one in 30 of the workforce in Northern Ireland, and consume 3% to 4% of the Assembly's budget. Its approximately £1 billion turnover would be roughly two and a half times that of the other four trusts which were all around £400 million. In

terms of keeping the system in balance, therefore, the performance of the Belfast trust was absolutely critical. If it performed well, the system overall was likely to perform well, but if it did not there was little scope for the other trusts to compensate.

Appleby had indicated a requirement for 7% increase in funding, although the Department had argued for more, without receiving much sympathy from the Treasury. But many interviewed expected that, at least in the short term and providing that devolved government was resumed, the Barnett formula would not determine their future. All the political parties would demand a 'dividend' from England, and significant investment was thought to have been indicated to be forthcoming from the Republic, particularly where it would enhance cross-border services. Another effect was expected to come from private investment and philanthropy. There was reported to be real interest in investing as Northern Ireland was "emerging from the darkness".

3.3.9 Regulation, UK networks and related issues

Professional regulation issues also posed a challenge. It was accepted it would be both expensive and probably inappropriate for the Province to have its own professional regulatory machinery, but being part of the UK also had disadvantages. Northern Ireland had the same GP contract as England, and also had found it a considerable cost. The Northern Ireland experience so far was that the targets were not stretching enough, typically with 98% to 100% coverage/achievement. What they needed was something that enabled specific targets for individual practices relevant to their patient populations, but this was proving a challenge. Negotiations for the contract had been driven from London, with Northern Ireland being only one voice at the table. They now had only limited ability to adapt the result, and many voiced a desire for a different approach in future.

There was repeated mention of the Foster[iii] and Donaldson[iv] reports.[10, 11] A common view was that the way Foster had operated had been much more appropriate in terms of recognising devolution issues. The process was reasonably open to the devolved administrations. This was not the case with Donaldson. It was reported that the author's initial intention had been to share its contents with the other Chief Medical Officers

iii The Foster Report flowed from the work of a review of non-medical professional regulation which was set up in March 2005 by the then Secretary of State, John Reid. It dealt with the regulation of healthcare professionals other than doctors. The short-term origin of the review was the need to respond to the reports of the Shipman Inquiry and particularly their comments on the General Medical Council. The Department of Health's Director of Workforce, Andrew Foster, carried out the review.

iv The Donaldson Report was produced by the Chief Medical Officer for England. It was commissioned by the Secretary of State for Health following publication of ***The Shipman Inquiry: fifth report***. Harold Shipman was a general practitioner who worked mainly in the northwest of England. (The Shipman Inquiry concluded that the doctor killed about 250 of his patients between 1972 and 1998, of whom 218 were positively identified.) Dame Janet Smith, who chaired the Inquiry, concluded that local NHS organisations did not at that time have systems in place that would have allowed such conduct to be detected. She was highly critical of the General Medical Council, concluding that its culture, membership, methods of working and governance structures were too likely to support the interests of doctors rather than to protect patients.

(CMOs) only on the day it was published. In fact, it was said, the non-English CMOs saw the draft paper belatedly, "copied via another route". The process of developing the report's recommendations was not felt to be as open as had been Foster's.

Northern Ireland welcomed and benefited from a variety of UK and international networks. People spoke of the benefits that were coming from the Public Health Observatory. A variety of links with Scotland were mentioned. These including clinical links between those involved with service commissioning. However, managerial links with Scotland which used to be strong were now said to be eroding. Respondents said that people saw less value in them when their systems were different. For the same reason, there were said to be fewer links through the NHS Confederation. This was seen as less valuable than it was as the number of organisations that could be members reduced.

3.3.10 Reflections

Northern Ireland offered what one respondent called a "stop–start story". Another offered his own categorisation of the history. The period 1990 to 1995 had been about general management, he said. The period from 1996 to 2000 had been about trusts, competition and general practice. The period from 2000 to 2005 had been about safety and governance. The period from 2005 to 2010 would be about performance.

There was a considerable degree of enthusiasm within the health service for the arrangements that had been put in place. For some people this was tempered with regret that some of the organisational proposals had not been radical or innovative enough. Most were concerned about the politics of health after resumption of devolved government, and hoped that some of the worst effects of the previous experience could be avoided.

The positive messages were about the achievements so far, and the building blocks that had been put in place. These included:

- a strengthened approach to performance issues, which had increased access and brought down waiting times
- new models of care that integrated health and social care across primary and secondary boundaries
- imaginative approaches to the management of long-term conditions
- a real focus on addressing health improvement and health inequalities
- ownership of the agenda by those by with the energy and ability to deliver change
- "Empowerment of people, not just involvement".

In summary, the plus points had been the public health strategy, the investment strategy, and innovative ways of working. The negatives had included the accentuation of local politics, and the learning curves of people unused to the responsibilities of government. There had been swings between bureaucracy and political leadership, and there had been a lack of clarity, and political interference, about performance issues.

Now, although there were great opportunities, the management and leadership challenges in the service had never been more difficult, and some people were concerned about how

managers could be better supported. The world was hugely demanding and this was affecting management morale. Optimists looked forward to a different pattern of hospital provision with more support in the community. There should be a stronger mixed economy of service provision, and the workforce (which should be around the same size as currently) should be more skilled. Value for money would be part of everyone's thinking, and the population would be more realistic in their expectations. As one respondent commented, at the time of the research the Northern Ireland health and social services system was a "work in progress".

3.4 Northern Irish attitudes to health and social care services

Public attitudes to health and social services in Northern Ireland are tracked by annual surveys commissioned by the Department of Health, Social Services and Public Safety. For most categories, comparative data is available for the four years 2003 to 2006.[12, 13, 14] The surveys reveal high levels of satisfaction in most of the categories surveyed. The overall level of satisfaction with health and social services in Northern Ireland in 2006 was 82% (people saying they were 'very satisfied' or 'satisfied'). This was an increase of 4% over the 2005 figure (a real increase even when sampling error is taken into account) and was the highest level since the series began in 2004.

Satisfaction with GP services was very high (95%), a figure which had remained virtually the same over the four years. Overall satisfaction remained high even though only 53% of users were seen by their GP within two days of making an appointment and with 17% reporting they had to wait longer than a week to see their GP for routine/non-emergency appointments. Satisfaction with waiting times for routine appointments was 74%, and with arrangements for emergency appointments 81%. The two most commonly suggested improvements for GP services were shorter waiting times and lists, and better arrangements for appointments.

Satisfaction levels with community nursing, pharmacy and dental services were very high (91%, 99% and 96% respectively in 2006), all figures which have remained virtually constant for the period 2003 to 2006. Satisfaction levels with hospital outpatient services had risen from 88% to 96% over the period. In terms of possible problem areas, satisfaction with accident and emergency services was 71% in 2006, the same level as 2003, but lower than in the intervening two years. Nearly half of accident and emergency service users who suggested a change called for reduced waiting times.

Given some of the concerns about service reconfiguration and possible hospital closures, the latest survey showed that three in four people would be prepared to travel further for a health service if they could get it sooner and the same number would be prepared to travel further for a health service if it were of a better quality. Another possibly significant finding was that 16% of those surveyed had used their own funds to pay for health or social service in the last year (this did not include payment for health insurance). This was twice the level reported in 2004 (the first year for which figures were available). However,

the sample size was small and payment categories were dominated by payments to opticians and physiotherapists, so caution was needed in reading too much into these figures. Finally, 32% of respondents said that funding problems and delays were the biggest problem facing the health service.

3.5 Health in politics and the Northern Ireland Assembly election 2007

Much of the election rhetoric was about the problems of the past, the tensions between the different parties and factions, and the commitments needed from Sinn Féin if devolved government was to resume. Particular policy issues were contained in all the manifestos, but tended to be addressed only after the main political issues around power-sharing had been explored. The comments and commitments about health were both disparate and wide-ranging. Few major themes were common to all manifestos. In terms of structure and governance, it should be noted that the manifestos of four of the five parties which ended with seats in the Executive restated in their manifestos their opposition to the RPA's seven-council model of local government. Only Sinn Féin supported this, which it did because "it provides the best model for equality and fairness".[v]

In terms of the individual manifestos, the Democratic Unionist Party's manifesto placed emphasis on the needs of older people, for whom health and social care must improve. It wanted patients to have the best care in the appropriate environment, with independence encouraged. More domiciliary, residential and nursing home places were required, as well as better respite provision. The party wanted to see free personal care provided as soon as circumstances permitted. It cited the Appleby Report's conclusion that the health service in Northern Ireland had suffered from long-term under-funding relative to the rest of the UK. It expressed determination to ensure the Government delivered in full the resources required to complete proposed capital development plans.

The resources Northern Ireland had must, it felt, be used to maximum effect. While the proposed reforms of health structures arising from the RPA provided opportunities, they must be accompanied by new ways of operating. The DUP argued that health was one sector that would benefit massively from local decision-making and greater accountability. The focus must be on investing in health promotion, early intervention and prevention of illness at community level. The DUP supported the extension of National Institute of Clinical Excellence (NICE) guidance and recommendations to Northern Ireland, so that

v On 25 May the Environment Minister in the new Executive, Arlene Foster, said she was committed to winning consensus on the shape of future local government. While the Local Government Taskforce had produced some very good work, particularly in relation to the modernisation of local government, four of the five political parties represented on it had participated on the basis that they remained fundamentally opposed to the seven-council model which had been agreed by the previous administration. The Minister said it would be preferable if the parties reached consensus on whatever number of councils was needed to achieve strong, effective and efficient local government and that she would be working with the Executive to consider how to proceed in relation to the decisions of the previous administration.

patients could be assured of the same standard of care as in the rest of the UK. The DUP welcomed the RPA's improvements which would streamline decision-making and reduce bureaucracy, but believed that reducing the number of local councils from 26 to just seven would weaken local government and make it more remote and unrepresentative of the needs of the local community. It had ensured that, in the event of devolution, this would be a matter for the Assembly to resolve and a cross-community vote would be required to proceed with a seven-council model.

The Ulster Unionist Party stressed their commitment to quality public services, and spoke of the way local accountability, strategic direction and targeted investment that a Northern Ireland Executive could bring to public services would stand in stark contrast to their mismanagement under Direct Rule, "in which remote government by press release has been the order of the day".

Specific health commitments included:

- moving, during the course of the first Assembly, towards free prescriptions for all – modelled on the Welsh Assembly's policy and restoring what it described as a key principle of the NHS
- an investment package for dentistry – particularly ensuring that dental practices could invest in oral health promotion
- extending NHS Direct to Northern Ireland, thus enabling patients to have access to NHS staff and advice 24 hours a day
- the Executive and the Assembly Health Committee promptly considering the recommendations of the Appleby Report, particularly its proposals for more efficient use of resources and better performance management.

The Social Democratic and Labour Party (SDLP) committed itself, among other things, to investing in health promotion and primary care; tackling health inequalities to reduce the burden on acute care; and improving access to NHS dentistry services across the North. It wanted to reform government, having "pioneered the advantages of an all-island approach to issues such as infrastructure, economy, health and education". It was committed to continuing to oppose the seven-council model. The SDLP would work to secure a model that ensured effective local representation, value for money, equality of opportunity and quality services for rate payers. It was committed to improved cross-border arrangements regarding acute hospitals and GP out-of-hours services. Its investment goals included health promotion, health inequalities, hospitals, access and mental health.

Sinn Féin stated its commitment to:

- fully resourcing and implementing the Investing for Health strategy.
- dramatically reducing or eliminating treatment waiting lists, and ensuring that all waiting lists were managed on the basis of clinical need alone
- opposing privatisation of healthcare services and staff.

It spoke of re-establishing the All-Ireland Ministerial Council, expanding the areas of all-Ireland cooperation and increasing the number of all-Ireland Implementation Bodies.

Sinn Féin was committed to open and transparent representative and participative governance, and believed that democratic decisions should be made at as local a level as is feasible, with the Assembly providing strategic direction, and overseeing and monitoring standards of public administration. It reiterated its opposition to using quangos to administer large areas of public policy because appointees were not democratically accountable. Alone among the major parties, the Sinn Féin manifesto supported the RPA's seven-council configuration.

Sinn Féin said it would promote the Equal Right to Healthcare. The health service was critically in need of a radical reorganisation and a massive injection of finance. But:

> *Instead, British Direct Rule Ministers have slashed funding further and used the Review of Public Administration to introduce failed neo-conservative policies into the Six Counties, paving the way for privatisation of healthcare and rewarding those with vested interests. Sinn Féin would seek to reverse this, to ensure that no further steps are taken to privatise the health service.*[15]

In its health policy, Healthcare in an Ireland of Equals, Sinn Féin had outlined a vision for a future all-Ireland health service accountable to the communities it served. To advance this, Sinn Féin in government would work to:

- fully resource and implement the Investing for Health strategy developed to tackle the socioeconomic and cultural determinants of ill-health
- establish a Rural Health Task Force to address the issues of unequal access to healthcare in rural areas, and border areas in particular
- dramatically reduce or eliminate treatment waiting lists, and ensure that all waiting lists are managed on the basis of clinical need alone
- oppose privatisation of healthcare services and staff
- introduce enabling legislation to abolish prescription charges.

3.6 The new Northern Ireland administration – first steps

One of the last announcements by the direct rule health minister Paul Goggins was to welcome the responses to proposals in the Health and Social Services (Reform) (Northern Ireland) Order 2007, which created the legislative framework for the new health and social care organisations, including the new Health and Social Care Authority and seven primary care-led Local Commissioning Groups within it. Replacing the existing four Health and Social Services Boards the Authority would commission services on a region-wide basis and performance manage the new trusts.

The Minister for Health commended the legislation to the incoming Minister, Executive and Assembly. He commented that he was:

> *encouraged by the positive comments we have received which give clear indication that the proposals will deliver more effective, responsive and integrated services and bring real decision making to local communities ... I am particularly pleased that these proposals are now ready to be considered at an early stage by the new devolved administration.*[16]

When the Northern Ireland Executive was re-formed in May 2007, portfolios were allocated using the D'Hondt formula. Whereas in the previous administration the health portfolio had been one of the two allocated to the nationalist party Sinn Féin, in the new administration it became one of the two portfolios held by the Ulster Unionist Party. The new health minister was Michael McGimpsey. In early announcements the Minister for Health committed £28 million in funding for two new Health and Care Centres in Belfast. These would make available a wide range of health and social care services, such as family planning and orthodontics, nutrition and dietetics, and physiotherapy. The development of health and care centres was intended to contribute to a more accessible health and care system, with local people receiving a more complete service being provided by a wide range of primary care professionals in the community.

In response to a private member's mention calling on him to establish a cost and benefit review for the purpose of abolishing health prescription charges as had been done in Wales, the minister commented that the time was right for Northern Ireland to look at the issue. On free personal care, the Minister said that he had asked officials to bring him an early assessment of the costs and implications of a number of different options. He said that though the Ulster Unionist Party (UUP) had a manifesto commitment to free personal care, a report commissioned by the previous Assembly in 2001 had estimated the cost of implementation to be over £40 million. He had asked for an urgent and comprehensive update, which should consider the experiences of Scotland and Wales and identify the cost of any other potential options.

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4. SCOTLAND

4.1 Looking back

Jervis and Plowden's 2003 report[1] contained a précis of the quarterly monitoring reports submitted by the Constitution Unit's Scottish monitoring partners. For Scotland the comment was that, in monitoring events, there was a tendency to look for divergence in policy, which brought with it the danger of a focus on the actions of the Executive. This might inadvertently understate the impact of the Parliament. The monitoring reports showed that the parliamentary processes had been transformed not only at a national level, but locally as well. NHS bodies were having to think carefully about the way they engaged citizens and their parliamentary representatives in their work. The new politicians inherited a substantial health policy legacy, only partially implemented, so it was not surprising that it was only from the second year of devolution that policy, substantially different from elsewhere in the UK, began to emerge. Three policies stood 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.

The creation of NHS boards in Scotland and the erosion of NHS trusts as separate organisations stood in sharp contrast to the English model with its (then) emphasis on decentralised 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 was not so apparent in Scotland. Perhaps the most high-profile issue had been the subject of free personal care. Introduced in Scotland, it raised questions about the justice of elderly people in one part of the UK enjoying a benefit unavailable elsewhere.

Tackling waiting lists, the use of the private sector and identifying funding for free personal care for the elderly all had been issues which generated a great deal of heated debate in the Scottish Parliament and considerable comment and speculation in the media. This was particularly true of the use of the private sector in the treatment of NHS patients. New initiatives had been announced on mental health and bed blocking, the recruitment and retention of nurses, and the first heart care standards were also published. The 15 new unified NHS boards had gone 'live' across Scotland and the Scottish Cancer Group had released an implementation plan following the publication of the cancer strategy.

As the authors looked ahead, from May 2003, they had remarked that one issue in particular tempted speculation. It was the growing influence of the European Union. They remarked:

> *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.*

Given where things stand in 2007, and as discussed elsewhere in this report, these remarks were particularly prescient.

4.2 Scottish health policy – the key building blocks

The period covered by this report contained a number of major White Papers on health strategy, which were followed by the legislation enacting them. There were also important initiatives on aspects of the medical workforce and on aspects of public health, as well as many specific proposals targeting particular conditions or areas of need.

4.2.1 *Partnerships for Care*

In February 2003 the Scottish Executive introduced the health White Paper *Partnerships for Care*.[2] The White Paper built on *Our National Health: a plan for action, a plan for change*, which had been published two years previously, but moved on by developing a number of key issues. In particular it:

- positioned patients and national standards as key drivers of change in the health service, and frontline staff as leaders of the change process
- outlined ways in which the redesign, integration and quality of services could be systematically progressed
- sought a step change in Scotland's approach to health improvement as an essential complement to the modernised, patient-focused services of the 21st century.

In his introduction to the new paper, the then Health Minister Malcolm Chisholm said that a culture of care developed and fostered by a new partnership between patients, staff and Government lay at the heart of his vision for the future of the health service. He commented that two historic problems of the health service had been the divisions between primary care and secondary care, and between health and social care. Patients considered these as a single system, and the Executive had to create the 'care without barriers' that they wanted.

Within a new framework of national standards and inspection, frontline staff would be given the resources, the tools and the freedom to innovate and find better ways of delivering care. He also stated that he wanted to see more diagnosis, care and treatment

delivered within new Community Health Partnerships whenever that was appropriate and clinically safe. The changes would require significant investment. The Executive had already increased Scotland's health budget from £4.6 billion to £6.7 billion over the course of the Parliamentary session, and this would continue to rise by over 5% per year in real terms. The Scottish Executive would use the forthcoming 1% increase in National Insurance to fund a sustained increase in health spending. The Minister concluded by saying that the White Paper signalled a direction of travel and a way of going forward together. It also took a broad view of health and recognised that Scotland would never make the progress the Executive wanted without addressing the broad determinants of health within Scottish society. The White Paper confirmed that Scotland's health was improving, but remained poor compared to the rest of Europe, with an unacceptable health gap between the richest and the poorest communities. Action to close that gap pervaded the health improvement strategy outlined within the White Paper. Looking at services from a patient's point of view underpinned everything that the health service was seeking to do, and this amounted to "a massive culture change in the health service compared to the first fifty years of its history".

The drive to define national standards for healthcare was being taken forward in a more integrated way by NHS Quality Improvement Scotland. National standards were being set, performance was being independently inspected and the findings were being reported publicly for the first time. This would be backed up by effective intervention by the Executive, where necessary, to ensure that standards were met. The model of a modern health service in Scotland laid strong emphasis on partnership, integration and redesign. This involved a central role for primary care teams in new Community Health Partnerships, working with hospital services and in new relationships at community level between NHS Scotland and Local Authorities. The White Paper commented:

> *We are seeking to bridge the gap between primary and secondary care and between health and social care. In this way, we will enable health and social care professionals to look at the whole picture of care from a patient's point of view. We believe this is essential for achieving shifts in the balance of care and for developing the new models of care that meet patients' needs.* (p. 8)

Staff, frontline staff in particular, were to be the key agents for delivering the necessary change. The paper confirmed that:

> *In this White Paper we explicitly reject a command and control management approach, whether from St Andrew's House or local NHS Board headquarters. Instead we describe ways in which the centre can support staff by giving them the tools and the freedom to redesign services and lead change, in partnership with patients.* (p. 9)

The public, patients and staff expected the NHS at local level to be a single organisation with a common set of aims and values and clear lines of accountability. The Scottish Executive therefore would continue dissolving trusts, and would legislate to remove the powers relating to NHS trusts. It would require NHS boards to bring forward proposals, by April 2004 at the latest, to dissolve the remaining trusts. The Executive would also

place a duty on NHS boards to implement decentralised approaches that devolved responsibility to frontline staff. The Executive extended NHS board membership to strengthen clinical expertise and ensure that service delivery in local communities had a strong voice at Board level. It required the appointment of a Medical Director and the Chair of the Local Health Care Cooperative (LHCC) Professional Committee to each NHS board. These appointments were intended to play a key role in the transition to Community Health Partnerships. The Executive intended to maintain oversight of service delivery to ensure that national standards and priorities were met, and would intervene if necessary in the event of failure by NHS boards.

4.2.2 The National Health Service Reform (Scotland) Bill, June 2003

In June 2003 the Scottish Executive published the Bill bringing the White Paper's proposals into being. The Introduction of the National Health Service Reform (Scotland) Bill was greeted by a *Guardian* article under the headline 'Scotland goes its own way on NHS reforms'.[3] The Bill, the paper said, would wipe all references to NHS trusts in Scotland from the statute book and "will finally end the NHS internal market north of the border".

Quoting the Minister as saying the changes would "transform and modernise" the health service, the newspaper added that, for the first time, ministers in Scotland would have the power to intervene where local health services were perceived to be failing, a power that was already enjoyed by ministers in England. Commenting on the fact that the Scottish Executive, and the Health Minister in particular, had been criticised for taking a centralising approach by abolishing trusts, the newspaper further noted that the Bill, like the White Paper, made it clear that the idea was to devolve decision-making to the frontline as much as possible.

The newspaper further commented that, as devolution bedded in, the Bill also placed more 'clear blue water' between the health services north and south of the border – by what it left out as well as what it contained. Ministers had, for example, rejected the idea of foundation hospitals for Scotland, partly because the sheer size of the country would make a diversity of providers next to impossible. But the Scottish Conservative party's health spokesman criticised the rejection of the foundation trust option, saying:

> *A movement towards foundation hospitals and far greater choice for patients is an essential step in the right direction and it is a national scandal that the Scottish government continues its poverty of ambition for Scotland by refusing to take these crucial steps.*[4]

The Scottish National Party (SNP) said the reform initiatives were "long overdue" but expressed concern about the independence of the Scottish health council proposed in the Bill. The party's deputy health spokesman said:

> *I am concerned about the fact that the body set up to deal with public involvement is not independent from NHS boards as it may not be possible for them to be fully objective.*[5]

The Act came into effect at the beginning of September 2004.

4.2.3 *Building a Health Service Fit for the Future*

The next significant policy initiative was the appointment, in April 2004, of Professor David Kerr, who was asked to propose a national strategy for modernising the NHS and finding ways to preserve local services. His report, *Building a Health Service Fit for the Future*, was delivered in May 2005. Kerr described the proposals as a "20-year plan for the NHS". Despite the progress that had been made, Scotland, he said, still found itself suffering in comparison over a range of health indicators with its neighbours:

> *We find health to be Scotland's touchstone issue, with over 250,000 folk signing petitions to "save our health service" although quite from what remains a matter of uncertainty. Given the extraordinary health pressures that we face from a rapidly ageing population, dwindling birth rate, imposed working time directives from Europe, changes in working patterns, evolving technology and an ever-expanding health gap between rich and poor, it should be obvious to all that the status quo definitely cannot be an option.*[6]

Noting that plans to overhaul the system had caused controversy across Scotland, the report argued that the NHS needed to modernise in order to meet new rules over doctors' working hours, their pay, medical specialisation and stricter guidelines on standards of care. The problem was that many of the solutions that health boards had come up with so far had proved highly unpopular, as they often involved moving emergency and complex surgery from local hospitals to large, centralised hospitals.

In the consultations conducted during the preparation of the report, the issues most often raised by users included:

- maintaining high quality services locally
- improving waiting times
- supporting Scotland's remote and rural communities
- empowering clinical staff to meet the challenge of reforming the Health Service
- using new technology to improve the standard of care
- reducing the health gap between rich and poor
- ensuring that value for money was obtained across the NHS.

Kerr argued that what was needed was the transformation of the NHS through a series of "bold initiatives" that would provide a framework to deliver safe, quick and sustainable healthcare for the future. The need was to establish and empower systems for national and regional planning to create strong, cohesive health communities. He said that although patient choice was important, the views of the people of Scotland were that other things, such as honouring commitments to treatment dates and ensuring quality of care, carried greater weight. The practical implications from this included investment in patient pathways that spanned primary and secondary care; delivery networks of rural hospitals linked to and supported by the major teaching hospitals; a rational distribution of services between neighbouring hospitals; and national planning of complex service frameworks like neurosurgery and specialised children's services.

In planning the future of its NHS, Scotland needed to:

- ensure sustainable and safe local services, redesigning these where possible to meet local needs and expectations, and to specialise where required having regard to clinical benefit and to access
- view the NHS as a service delivered predominantly in local communities rather than in hospitals
- stress preventative, anticipatory care rather than reactive management
- galvanise the whole system including hospitals, general practice teams, social care providers, patients and their carers, to meet these challenges
- use new technology to improve the standard and the speed of care
- develop new skills to support local services
- develop options for change with people, not for them.

The Kerr report also included a re-statement of the values of the NHS in Scotland, saying that its basic ethos – free comprehensive care available to all – still commanded universal public support. The future of Scotland's health services needed to be built from that base. But a new approach was needed, based on getting the NHS in Scotland to work as a single, whole system. All of the partners in the system needed to realise that they were interdependent. And all partners needed to understand that everyone needed to change. The nature of the changes was summarised in a model comparing the current view with the evolving model of care required:

Table 4.1 Current and future models of care

Current view	Evolving model of care
Geared towards acute conditions	Geared towards long-term conditions
Hospital-centred	Embedded in communities
Doctor-dependent	Team-based
Episodic care	Continuous care
Disjointed care	Integrated care
Reactive care	Preventative care
Patient as passive recipient	Patient as partner
Self-care infrequent	Self-care encouraged and facilitated
Carers undervalued	Carers supported as partners
Low-tech	High-tech

Source: Building a Health Service Fit for the Future, p. 9

The report argued that Scotland needed to fully utilise the potential of its community hospitals, including importing to urban Scotland the model of the community hospital as a local hub (perhaps by bringing together a number of GP practices on to a single site where they could share access to diagnostic and other facilities). That would require a shift in resources. The report suggested that over time, the shape of Scotland's hospital

provision would change. It did not produce detailed prescriptions for the changes; however, one of the key messages of the Kerr report was about the need to improve the whole system. This would require:

- a clearer understanding of what the NHS was trying to achieve
- integrated, collaborative and coordinated working by the NHS and its partners across the professions and across traditional system boundaries
- excellent management, to ensure performance is aligned with the vision and that the NHS rewards those contributing to the whole system
- resource flows that channel additional investment to support service change
- an empowered workforce, able to lead the clinical change necessary to make this work.

4.2.4 *Delivering for Health*

The White Paper *Delivering for Health*, published in November 2005,[7] was the Government's response to the Kerr report. It was aimed at moving towards a system which emphasised a wider effort on improving health and well-being, through preventive medicine, through support for self-care, and through greater targeting of resources on those at greatest risk, with a more proactive approach in the form of anticipatory care services. It responded to the wishes of the people of Scotland to have more local healthcare, a more responsive NHS, and a greater say in the way their NHS was run.

Delivering for Health indicated the kind of changes patients and their families in Scotland should expect to see as the actions it contained were implemented:

- More health care would be provided locally, in GP practices, in community pharmacies or, increasingly, in Community Health Centres. There would be greater use of day case treatment.
- For people staying in less well-off areas, their local primary care team would have dedicated resources to reach out and help those with higher risks of ill-health.
- For people with long-term conditions, help and support would be available to help them play an increasing role in managing their conditions themselves.
- Older, frail people or those liable to frequent hospital admission would get coordinated care provided locally.
- Carers would be treated as partners in the provision of care.
- Patients would have access to their own Electronic Health Record, as would all the clinical staff treating them.
- People needing specialist treatment in hospital would get access to a good, safe service provided by the right person, even if that meant they would have to travel.
- People needing to go to hospital would have quicker access; more tests would be done locally, and lengths of stay would be planned and shorter.

Delivering for Health gave a commitment that patients would experience fewer cancelled appointments or procedures because of an emergency or because tests were not available. It further promised that, for people staying in remote and rural areas, the NHS would

provide them with a core set of services in rural general hospitals. The plans in the paper were to be delivered through the continuing development of the NHS as an integrated service. This would ensure that patients experienced a smooth and quick 'journey of care' wherever and however they accessed services.

The emphasis on integrating care would require multi-disciplinary team-working, requiring collaboration and coordination between professionals and across organisational boundaries. It required a partnership approach at all levels to achieve continual improvement in quality and value for money. It also required the NHS to deliver public health improvements by engaging with other public authorities.

Delivering for Health reported that organisational change within the Scottish Executive Health Department was being introduced to ensure a sharp focus on the delivery of key priorities and targets. This involved a new Delivery Group that would draw together and strengthen the performance management function, agreeing annual Local Delivery Plans with each NHS Board, providing systematic monitoring of performance, and playing a more assertive role in supporting or intervening. In addition, a new Group for Primary and Community Care was to help to prioritise the development of healthcare services in community settings and partnerships with social care services.

4.2.5 *Developing Community Hospitals*

A major feature of Scotland is its geography. The central belt apart, much of Scotland is marked by relatively low population density and scattered rural communities. A recurring theme of the earlier papers had been the need for provision appropriate to the needs of people living in remote and rural communities. A strategy for community hospitals which addressed these needs was set out in the report *Developing Community Hospitals: a strategy for Scotland*, published in December 2006.[8]

This noted that the Government's vision for the future provision of health services in Scotland, as set out in *Delivering for Health*, demanded a new approach. The expansion of community-based, primary care-led services provided a new challenge in both rural and urban areas. This challenge could be met in part by a new model of community hospital. The paper provided a blueprint through which NHS boards and their Community Health Partnerships could develop modern, locally sustainable community hospital services that were responsive to local community needs in a wider range of settings than currently existed. Importantly, the strategy moved beyond the vision of community hospitals in rural areas to include urban settings.

> *The strategy never loses sight of the unique relationship community hospitals have with their local populations. Nor should it. This strategy sees this kind of community facility used effectively in more places than the rural settings.* (p. 1)

The strategy envisaged NHS boards using new community hospitals as local resource centres in which to provide people with more holistic and integrated services quicker and closer to home. Local primary care resource centres and local community nursing services

were to be enabled to provide the majority of care for the local community alongside local general practices. It encouraged NHS boards to develop this agenda in partnership with, and with the support of others in the NHS, such as the Scottish Ambulance Service and NHS 24. It also stressed that NHS boards should adopt the new community hospital model for urban areas, providing services more locally.

4.2.6 Other initiatives

Other key health service developments during the period 2003 to 2006 included a paper on shaping the medical workforce, published in June 2004, and proposals on the Waiting Times strategy in December 2004. There were many initiatives aimed at addressing specific health conditions. In the public health arena there was the extremely significant, and widely applauded, introduction of the smoking ban, but also initiatives on healthier eating in schools and alcohol abuse.

4.3 Where is the Scottish NHS now? Views from the service

If the preceding section records briefly some of the main policy developments, what had been their effect? What did all this add up to by the end of 2006, in the views of senior health managers, civil servants and politicians?[i] In all the discussions, people were extremely positive about Scotland's position. Everywhere, there was a considerable impression of confidence and assurance. Respondents seemed to think that, even if they had not got everything right yet, things were definitely moving in the right direction. 'Single system working' – the changes in the organisation of health boards and the abolition of trusts was seen as having delivered, or being in the process of delivering, many of the desired benefits.

In looking back at developments since devolution, people were now seeing the period of the first Parliament very much as one in which new relationships were being formed, boundaries were being challenged, and not a great deal actually happened in health policy terms. By the time of the second Parliament, relationships had formed, the systems had begun to bed down, and there was a consequent improvement in delivery. In particular, a new focus on performance management had turned round the performance of the Scottish NHS, which had been flagging three or so years before. Many respondents saw the appointment of a new Health Minister, Andy Kerr, and a new Head of the Scottish Executive Health Department, Kevin Woods, as particularly important in bringing about this new focus on performance management.

In assessing achievements, people tended to admit that they were judging as much on potential as on the reality. Asked to mention major achievements in the period since

i This fieldwork was carried out in November and December 2006, before the Scottish election campaign got underway, and before the change to an SNP government.

devolution, everybody mentioned the smoking ban and, sometimes with prompting, the introduction of free personal care. After this the list tended to dry up. But the revised organisational arrangements, together with the time that had now been invested in developing partnerships both within the NHS but more importantly with other stakeholders, was believed to have formed a strong foundation for future developments.

The result was that, at the time, most of those involved in the Scottish NHS seemed particularly upbeat. One senior figure, when asked to identify negatives or downsides of the current situation, could not think of any. People tended to look in bewilderment at the South and what they perceived as chaos in the English NHS. Many people quite independently spoke of the English NHS as having "lost the plot". Rightly or wrongly, the Scots seemed convinced that market-type mechanisms in health were not the answer, and that the Scottish approach was superior to that of the English.

4.3.1 Governance and accountability

The original research had focused particularly on changes in governance and accountability arrangements as they applied to the health services. People described the then current situation in Scotland, where a very different sort of model of accountability was being used. This had both structural and behavioural dimensions. Structurally, trusts having been abolished and incorporated into the health boards, there were currently 22 health boards, of which 14 were geographical and the remainder were special health boards such as, for example, NHS Quality Improvement Scotland.

Superficially, the new governance model, particularly as it was being operated by the then Health Minister and the Head of the Scottish Executive Health Department (SEHD), appeared to have a refreshing degree of openness and transparency (although still not as much as some of those interviewed would have liked). Each year, in August, the Health Minister, accompanied by the Head of the SEHD, had held one-day meetings, in public, to review the performance of each health board. The days were constructed to include separate meetings with clinicians, patients, staff and other stakeholders. One respondent suggested that, given ministers' concerns that they were not embarrassed in public, what actually happened was that each side shared their briefing notes with the other, so that the public discussion was not quite as spontaneous as it might have appeared.

However, the approach did involve a public holding to account of each board, and the way the Minister ran the meeting focused on the board Chair, who was expected to answer every question himself or herself, at least initially, before involving the other executives. The Minister concentrated accountability very sharply on the Chairs, and had regular meetings with them throughout the year, at which performance expectations were made very clear. The Minister's meetings with Chairs were paralleled by meetings which the Head of the Scottish Executive Health Department held with chief executives.

People described Scotland as opting for a highly centralised structure, with performance management at the heart of it. These accounts seemed slightly at variance with the

repeated imperatives in the Kerr report and in *Delivering for Health* about the need for new cultures and ways of working that empowered frontline staff.[ii]

Not everyone contacted considered that the structure was correct, particularly as far as the number of health boards was concerned. There were views that the number of boards should be reduced, in the extreme case down to only three: in effect a regional model. This sort of reorganisation did not seem to be on the cards at the time, but it was thought that opportunities might be taken from time to time to reduce the number of boards. For example, the Argyll and Clyde board had been beset with difficulties, which had persisted for some time. Eventually, the decision had been taken to abolish the board and combine its activities with those of two neighbouring boards, rather than appointing a new Chair, non-executives and executives. At the time of the interviews the Western Isles Health Board had been in difficulties and it was thought that it might suffer a similar fate, although the geography and political concerns made this solution harder than in the case of Argyll and Clyde.

One important initiative on governance and accountability was an attempt to introduce direct elections to health boards. A commitment to "consult on introducing a directly elected element" to health boards was in the Labour manifesto for the 2003 Holyrood election, but was not taken forward by the coalition established with the Liberal Democrats. In 2006 a proposal for direct elections to health boards was introduced as a Member's Bill by Labour MSP Bill Butler. The Parliament's health committee backed the general principles of the Bill, but the proposals were opposed by the Health Minister and the Scottish Executive Health Department. After moving through the various stages of the legislative process, the proposed Bill was debated in Parliament on 31 January 2007 and defeated. The SNP manifesto for the 2007 election also contained a proposal for direct elections to health boards.

It remains to be seen what effect the change in government, the change of minister (now styled the 'Cabinet Secretary for Health and Wellbeing'), and the re-structuring of the Scottish Executive portfolios will have on approaches to the governance of the Scottish health services, as well as to health policy itself.

4.3.2 The relationship with England

Previous research, and discussions at meetings elsewhere, had produced examples of Scotland being "in bed with an elephant" as far as the relationship with the English health service was concerned. Actions by England were seen to have important and unwelcome implications for Scotland, perhaps unintended or perhaps insufficiently thought through in the context of devolution. Now, as far as health services were concerned, the situation had changed. The elephant might still be in the bed but, as one respondent put it, "if it moves it doesn't wake us". This positive view of the situation with health services was not

ii Interviews were not conducted with frontline staff, and it is possible to operate systems which simultaneously have strong centralised performance management and devolved operational responsibility.

reflected so strongly when matters concerning the professions were discussed. Here, numerous examples were cited of difficulties or tensions between the UK position (a position which frequently was seen as almost entirely dictated by English considerations and requirements) and that of Scotland. As devolution became more firmly enshrined, and divergence developed, difficulties around professional issues such as regulation, education and training, and continuing professional development, were thought likely to increase.

There had been indications, once the early days of devolution had passed, that the difficulties that had been caused by an English focus to the Department of Health's thinking were beginning to diminish. However, it seemed that recently things may have begun to get worse again. For example, the impetus for undertaking the Donaldson and Foster reviews was seen as generated by English considerations, and even when attempts were made to acknowledge differences in Scotland and Wales, often this was viewed as being done incorrectly.

Dr Brian Keighley, a GP and an elected member of the General Medical Council, was quoted in *The Scotsman*[9] as saying that some proposals in the Donaldson Report might not be appropriate for Scotland. "We don't have a Healthcare Commission or a National Patient Safety Agency," he said (both of which bodies were cited in the report). "It is all predicated on English structures and, to some extent, English problems." In contrast with the Donaldson Report, the UK Government White Paper which followed it[10] acknowledged the need for flexibility, to allow the devolved administrations to put in place arrangements that met their individual requirements while remaining within a UK-wide framework of common principles.

4.3.3 Scotland's international aspirations

The interviews were conducted when the European Commission's consultation on health services was in progress. In general, there did not seem to be a high level of awareness about the proposals, or the likely outcomes. It was sometimes suggested that the Scottish Executive Health Department would welcome something that would deliver legal certainty on issues of cross-border patient mobility, but the impression was that such issues were not high on the agenda. Scotland's international aspirations featured as strongly in these discussions as they did in the original interviews. There were a number of examples of Scotland seeking to form links and exchange experience with other administrations which they felt had similar problems and opportunities. These were not necessarily the other smaller countries within the British Isles but, for example, some of the smaller European countries, particularly the Nordic ones. The new Scottish SNP government has already indicated its intention to strengthen links with Europe and, as discussed elsewhere, has suggested that Scotland should lead UK negotiations with the EU in areas where it has the strongest interest, such as fisheries policy. Scotland and Europe, or Scotland in Europe, will be issues to watch over the coming months and years.

4.3.4 The challenge for Royal Societies and other professional groups

The original devolution and health research had indicated a concern that professional networks might fragment after devolution. In general, this does not seem to have been the case. Certainly from the perspective of the more senior clinicians, networks were seen as being as strong as ever. One respondent did say that the Scots perhaps travelled less than they did to meetings in England, but this was not through any deliberate exclusion from such networks.There was evidence that a number of the professional societies had struggled with the new challenges that devolution had brought. As the earlier reports had expected, the development of new governments in Scotland and Wales, and the consequent requirement to lobby and influence in three places rather than one, had challenged the governance structures and ways of working of professional bodies. Even some of the bigger organisations still seemed to be in a process of adjustment, reviewing and changing their governance structures to meet the new requirements.

As well as the large number of UK-wide professional bodies based in London, there were a smaller number which were based in Scotland. They reported a slightly different challenge, that of reminding the Scottish bodies with whom they interact that they do have wider concerns and responsibilities, including international markets for their qualifications, and that they could not simply respond to parochial Scottish concerns.

In education, there appeared to be a tension between the health agenda and the higher education agenda. The views expressed during the original project were that Scotland deliberately overproduced doctors, knowing that it could keep the best and export the others, to England and elsewhere. There now seemed to be more of a sense in Scotland that it should only produce sufficient for its own needs, and this was colouring some of the discussions about investment in higher education. The higher education position had been complicated by the different approaches in England and Scotland to student loans. Yet from the point of view of Scotland's universities, they were competing in an international market and argued that they could not simply respond to local supply and demand issues.

4.3.5 Reflections

It would be wrong to say that the interviews revealed a transformation in the Scottish position, because previously those interviewed were always fairly confident that Scotland would meet the challenges of devolution in health. But certainly the more recent research identified a considerable feeling of confidence and success, and a much more relaxed position about the relationship with England. Many of the uncertainties and doubts seemed to have dissipated.

The Scots seemed quite confident that they were going in the right direction, although people recognised there were still many challenges ahead. It did seem that one of the things which may have helped ease the situation was the improvement in the performance of the Scottish health services, judged by things like waiting times. Because of this, there

was less room for unfavourable comparisons with the situation south of the border, and the media were felt not to be as hostile as they were in the early days of devolved government. Another of the reasons that the pressure on the Scottish health service may have reduced somewhat might have been the state of the English NHS, as reported in the media. Were the English NHS to be seen to get its act together, overcome its financial problems, and increase productivity, then pressures in Scotland to improve performance further might have become much stronger.

Scotland has entered a new era with its new (minority) government, although it is hard to judge whether that government will be able to last its full parliamentary term. While it does remain in place, it will bring challenges both for Scottish health policy and for that of the UK. Some of the early steps by the SNP administration, for example, looked likely to challenge proposals for hospital service reconfiguration. Nevertheless, the 'snapshot' revealed by the fieldwork was that, at the end of 2006, the feeling in Scotland was that devolution in health had been a considerable success story.

4.4 Scotland's attitudes to public services

The Scottish Executive commissioned research on attitudes to government and public services in post-devolution Scotland. In doing this they argued that, although the Scottish Executive and Parliament now had greater freedom to set policy in Scotland, it was not necessarily clear who the Scottish public would hold responsible for improvements or reductions in standards in public services. Did they hold the Scottish bodies responsible for all policy in Scotland, including reserved matters? Did they continue to lay credit and blame at Westminster's door, even in areas where policies were set in Edinburgh? Or were they able to distinguish who was responsible for different areas and attribute responsibility accordingly? The series of Scottish Social Attitudes surveys addresses such issues.[11] The results are interesting, not least because they show the complex associations between policy and performance that appear to persist in the minds of respondents.

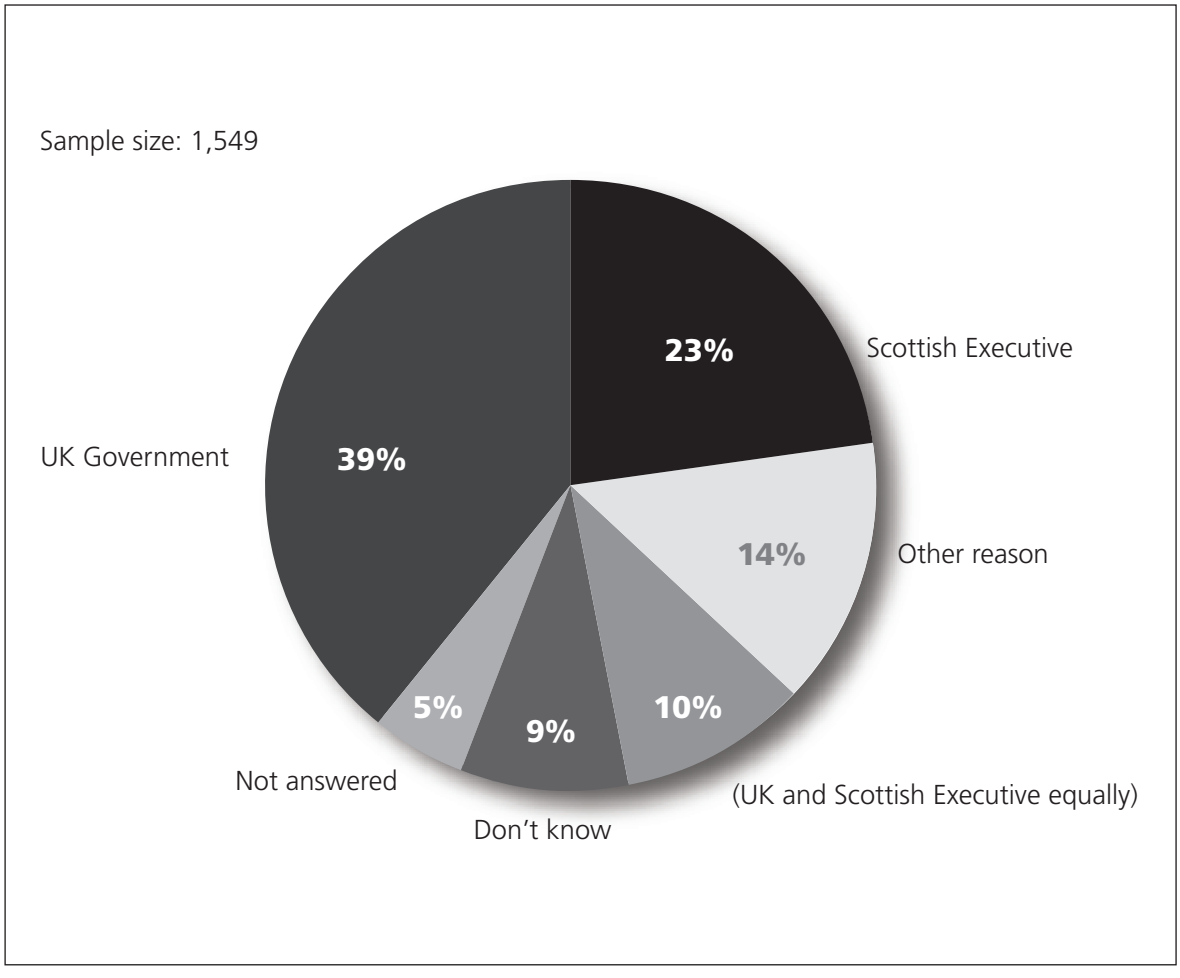
In both 2004 and 2005, the most commonly chosen item when people were asked what the Scottish Executive's key priorities should be was "improve people's health" (26%), which ranked just above "cut crime" (23%). Yet even health, the most commonly mentioned item, was picked by only around one respondent in four. When people were asked whether they thought standards had increased, stayed the same or fallen in the last year, the proportion of people saying standards had fallen was no higher than the proportion saying they had increased for four of the five areas the survey examined. Indeed, more people felt living standards and education had improved (28% and 25% respectively) than thought they had fallen (21% and 16%). But the health service, in contrast, received a less favourable evaluation, with more than twice as many people saying standards had fallen (36%) as say they have increased (17%). Even so, the most common perception of each area is that things had stayed the same (38%).

Although these findings reveal rather disappointing public attitudes towards the health service, it should be noted that assessments of individual NHS services tended to be much

more favourable than the overall judgement. When satisfaction with individual services was examined, seven in ten were satisfied or very satisfied with their local general practitioner services, and around five in ten said the same for outpatient, inpatient, and accident and emergency services. There was also some evidence that people felt that standards were improving, although there was no room for complacency. The 'net balance' scores for standards in the health service had been consistently negative since 2001, but they were much less negative in 2005 (–19) than in 2004 (–28). This suggested recent improvements in public views of health service performance.

In the context of devolution, it is important not only to know what people think of public service performance, but who they blame (or praise!) for it. Interestingly, despite the fact that decisions about Scotland's health service are devolved, the 2005 survey found that almost twice as many people held the UK government responsible for standards over the past year as did those who held the Scottish Executive responsible (in education, the figures were about the same).

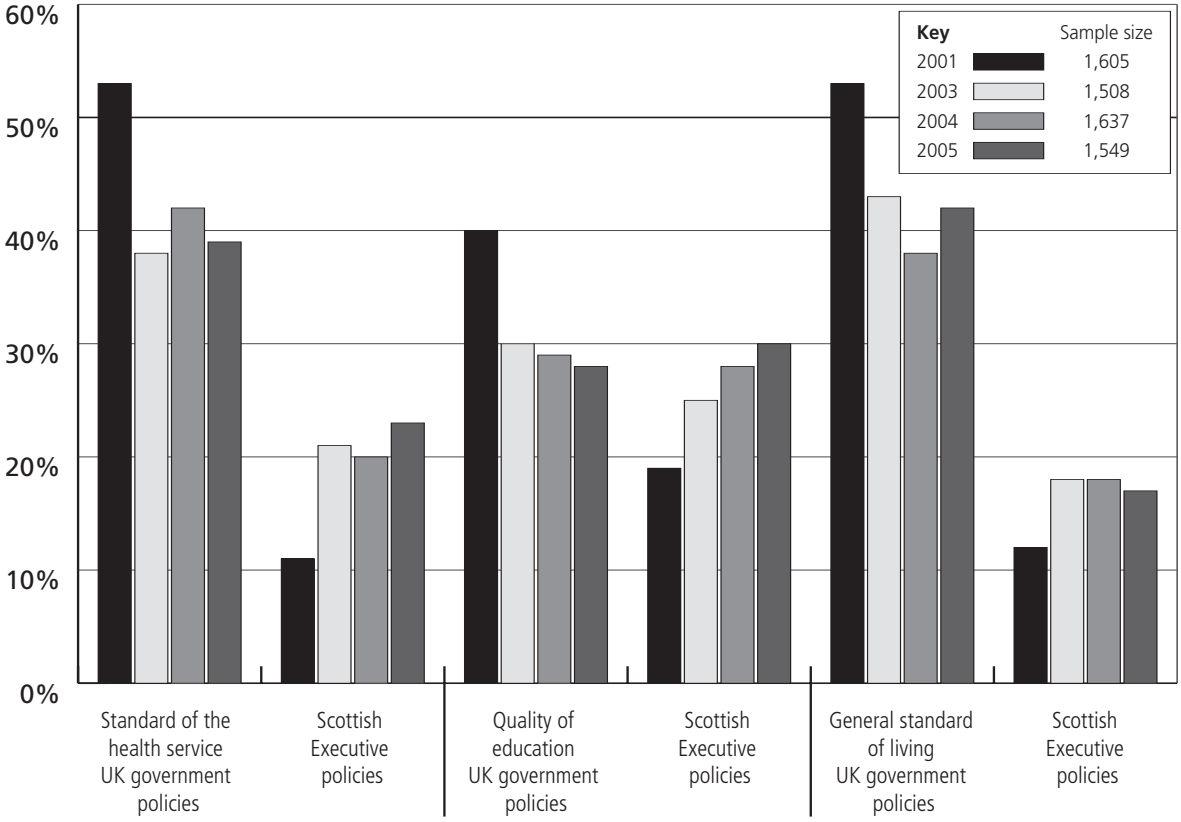
Figure 4.1 Perceptions of responsibility for standards in the Scottish health service



Source: Scottish Social Attitudes Survey 2005

The authors of the analysis suggested that the proportion of people who thought standards in public services were the result of Scottish Executive policies might be expected to increase over time. There was evidence that, for education and health, this appeared to be true. It was suggested that, by diverging from UK government policy in these areas (for example by introducing free personal care for the elderly and by abolishing tuition fees), the Scottish Executive may have increased awareness of its responsibilities for health and education.

Figure 4.2 Responsibility for public service standards in Scotland, 2001 to 2005



Source: Scottish Social Attitudes Survey 2005

Knowing who people hold responsible for standards in public services overall does not necessarily indicate who is credited for perceived improvements and who is blamed for perceived deteriorations. It is quite possible that these are not assigned to the same bodies. Park and McCrone's study[12] found a "reverse symmetry" in attitudes in their analysis of the 2003 survey data. Where standards were seen to have *declined*, the UK government was most likely to be held responsible, whereas among those who thought things had improved, the Scottish Executive was most likely to be given the credit. A very similar pattern was evident in the 2005 data. In 2005 people were somewhat more likely overall to attribute responsibility for performance to the Scottish Executive than they were in

2001. This similar increase for both credit and blame appears to hold for both health and education. That is, the Scottish Executive appears *both* more likely to be credited with increases and slightly more likely to be held responsible for decreases in standards than it was in 2001.

The analysts comment that, as in previous years, in 2005 negative evaluations of the health service stood out. Although views were less negative in 2005 compared with 2004, it remained the case that more people thought standards in the health service had fallen in the past 12 months than felt they had improved. However, overall there was some evidence that people were becoming more likely to attribute responsibility for standards in key devolved policy areas, like education and health, to the Scottish Executive: "If the trends found in this report continue into the future it seems likely that the performance of key public services will increasingly be attributed to the Scottish Executive, rather than UK government policies" (p. 19).

There are two important messages here. The first is that the relatively confident view reported from the health service is not matched with quite so much enthusiasm from general public surveys. The NHS in Scotland still has to win the argument here. But there is another finding which, in the longer term, is perhaps more important and more encouraging. Jervis and Plowden's devolution and health report, cited above, commented (p. 75) that in Scotland and Wales, "making devolution in health work" was associated with concepts of "taking ownership" of the national health systems and producing something that fitted the culture, traditions and aspirations of each country. One senior public health doctor explained her support for devolution because "it would mean the Scots have to take responsibility for their poor health status, and stop blaming it on England".

The evidence from the surveys of attitudes to public services may show that Scots are starting to accept that the responsibility for performance, whether it is judged to have got better or worse, lies in the hands of their government. As yet, this is not the majority view, but the move is in the right direction. This sort of change of mindset will take time, but the developments seem encouraging.

4.5 The performance of the Scottish Health Service

Spending on health in Scotland rose from £6.1 billion in 2001/02 to £8 billion in 2004/05. Much of this increase in funding was expected to be taken up by cost pressures such as the UK-wide pay modernisation initiatives for consultants, GPs and other NHS staff. The 2004–2008 spending plans indicated that total spending would rise to £10.3 billion by 2007/08. Expenditure per head of population in Scotland was set to remain approximately 20% higher than that in England.

The interviews indicated a general belief that the performance of the Scottish NHS had improved markedly towards the end of the period covered, although it had been lagging earlier. Alan Langlands, writing at the beginning of 2006, commented that:

> *There is some evidence that the NHS in England is outperforming Scotland in terms of growth in investment and improvement in waiting times but Scotland's resolve on health improvement and its willingness to play a long game in tackling deep-seated health problems seems stronger.*[13]

There were concerns about the ability of the Scottish NHS to meet waiting time targets. In August 2004, a report from Audit Scotland did find that NHS Scotland was likely to meet the majority of its targets on reducing waiting times, although it also argued that ministers should do more to show how the record amount of health spending was benefiting patients. The report recognised significant changes in healthcare delivery, and falling death rates for cancer and coronary heart disease. It also found that there was little explanation on how specific targets were achieved. In responding to the Audit Scotland report, the Deputy Health Minister Tom McCabe agreed that the NHS needed to improve the coverage and quality of management information on spending.

The report found increased funding and new ways of working were benefiting patients. In particular, it found that medical advances were changing the treatments that patients received and more people could be treated in community settings rather than in hospital. It noted that Scotland still suffered from high death rates in areas such as cancer, heart disease and strokes, in comparison with the rest of Europe.

The Conservative health spokesman David Davidson acknowledged that investment had been made, but said waiting lists had continued to rise because the health service in Scotland was: "controlled, directed and dictated by ministers".[14] In the same article the Scottish National Party health spokesman was quoted as saying:

> *There clearly needs to be a further explanation about how targets that the executive has set will be achieved, otherwise it will be almost impossible to say for certain whether the overall performance of the health service has improved.*

Later that year, in November, as figures showed that significant numbers of patients were continuing to wait more than six months for outpatient appointments across Scotland, the Health Minister confirmed that he would use private health care to help cut waiting lists. He stated that he was looking to the private sector to provide additional capacity within the NHS, and suggested private companies would be tied to long-term contracts but that proposals would not lead to staff leaving the NHS to work privately. Opposition parties said the plans were a U-turn by the Scottish Executive, and doctors' leaders expressed concern. The Minister denied that this involved a political turnaround by the Executive, saying that the NHS in Scotland had been using the private sector for many years. Rather, he said, his intention was to make sure the NHS engaged with the private sector more strategically, and perhaps on a more long-term basis, in order to ensure waiting lists were reduced. He was quoted as saying that:

> *What I want to bring here to the health service in Scotland is a supplementary support, not to replace the National Health Service but to supplement the health service.*[15]

By December 2005, Audit Scotland was confirming an improvement of the performance of the NHS in Scotland, in key areas such as availability of treatment, and also in death rates in cancer, stroke and heart disease. The waiting list issue, however, did not go away. In September 2006, a report in *Scotland on Sunday* claimed that Scots had spent £25 million from their savings on privately funded operations the previous year after deciding they could not face lengthy waits for NHS treatment. It claimed that more than 8,500 patients in Scotland without medical insurance had spent an average of almost £3,000 each of their own funds to pay for surgery. It was claimed that they did so because they faced waits of up to a year for NHS treatments for procedures ranging from hip replacements and cataracts to hernias and knee operations.[16] The figures quoted by the paper had been provided by the private hospital sector, and claimed to show the numbers paying for treatment had risen by one-third since 2003. If those with medical insurance were included, a record £105 milliion was spent on private hospital treatment in Scotland in 2005, a 25% increase since 2003. The total number of patients admitted for private surgery increased by 12% over the same period to 36,800. Medical insurance paid for 23,000 while some 5,300 patients had their care paid for by the NHS under waiting times initiatives introduced in 2005 by the Scottish Executive, and the remaining 8,500 paid for their own treatment.[iii]

Waiting times were not the only point of controversy. NHS 24, the confidential telephone advice and health information service available across Scotland, had been the subject of criticism since it was set up in 2002. Particular concerns were with the call-back system which, it was claimed, left many without medical advice for hours on end. In late 2004 there were two separate incidents where callers to the service died after receiving wrong or delayed advice. An independent inquiry which reported in September 2005 was extremely critical of some of the management failings within the NHS 24 operation.[17] But it also pointed to problems with the management of major projects within the Scottish NHS, and argued that the Scottish Executive Health Department needed to strengthen its handling of such initiatives.

The Health Department Delivery Group was established to ensure the best financial performance from the NHS. The Group was led by a Director of Delivery, bringing together and building into a single team the National Waiting Times Unit, the Centre for Change and Innovation, the Performance Management Division and others. The government also introduced more rigorous financial monitoring for the Health Department itself. The current performance management arrangements were replaced with local delivery plans, negotiated between each Board and the Executive, consisting of agreed, sharply focused, quantified local actions. The Delivery Group was expected to work with better-quality, up-to-date regular management data, to enable accurate tracking of boards' performance against all the agreed local delivery plan targets.

iii All figures are approximate

4.6 The politics of health

4.6.1 Single issue politics

Health service issues, of course, can easily form a focal point for local political opposition to unpopular policies. In England, in the 2001 general election, Dr Richard Taylor defeated a sitting government junior minister in the Wyre Forest constituency, having campaigned on the single issue of saving the local Kidderminster Hospital, which the government proposed to close. Taylor retained his seat in the 2005 election, becoming the only independent MP to retain his seat for a second term in the House since 1949.

Scotland has also seen such single issue health service campaigns. Dr Jean Turner, a general practitioner, stood at a by-election in 2001 in the Strathkelvin and Bearsden constituency on a 'save Stobhill Hospital' ticket. Although not elected, coming second with 18% of the vote, she stood again as an Independent in the 2003 Scottish election and beat the sitting Member of the Scottish Parliament (MSP), taking 31% of the vote. Dr Turner stood again in 2007, but lost the seat to the Scottish Labour party.

In 2007, David Smith, a surgeon from the Victoria Infirmary Glasgow, stood in the Glasgow Cathcart ward, demanding better healthcare provision across the south of the city. Smith, who had been a consultant at the Infirmary for more than 30 years, said the replacement hospital being built would not deliver. He claimed that the local health board had been reducing services in that part of the city for 15 years.[17] Smith came third with 13% of the votes, behind Scottish Labour and the SNP. A 'Save our NHS Group' also fielded candidates in the 2007 Scottish Parliamentary elections.

4.6.2 The Scottish Parliamentary and local elections 2007

In the run-up to the Scottish election May 2007, the Scottish National Party held a significant lead in the opinion polls over the Scottish Labour party, which then formed the government with the support of the Liberal Democrat party. This indicated the real possibility that there could be a nationalist government with a commitment to political independence for Scotland. Because of this, the SNP's proposals, the party's economic policies, and the future of the Union were the dominant themes of the campaign. The Labour leader, Jack McConnell, focused the party's election manifesto on education, although debates on this and most other specific policy areas tended to be drowned out by the clamour about independence.

In health, there was a degree of similarity in all the manifesto commitments, certainly as far as local and rural services were concerned. The Scottish Conservative party's manifesto was critical of what it claimed was the Liberal–Labour government's mission to centralise Scotland's health service. Its agenda was "depriving local people of what they desire – an array of quality healthcare services close to home". The party offered commitments of a tariff system with more choice of elective treatment, and actions on dentistry and mental health, among other topics.

The Scottish Labour party manifesto included proposals on health inequalities, offered further reductions in, and guarantees about, waiting times. It promised more community hospitals and a set of core services to be provided in rural general hospitals, and actions on children's health. The Scottish Liberal Democrats also focused on local services, stating that: "every community should have access to improved local health facilities, with a wider range of services under the same roof". It promised to begin a major building programme for 100 new local health centres which, in many cases, would mean new purpose-built facilities and in some areas would mean expanding the capability of community hospitals to provide minor surgery, or funds to improve the facilities and services on offer at existing health centres. A strategy would be introduced for sustaining small rural and community hospitals as part of a network of rural hospitals to support remote communities. There were also pledges about the recruitment of 2,000 more nurses and actions to support carers, as well as a consultation on a new total waiting time guarantee.

The SNP manifesto stated that patients expected to have local access to core services like accident and emergency and maternity services. It therefore promised that: "an SNP government will support this expectation by operating a presumption against the centralisation of core hospital services". It further promised that, to ensure that this was the case, it would introduce direct elections to health boards, promising that at least half of health board members would be elected by the public. It further suggested that those elected would be encouraged to serve on their local community health partnership as well as the health board. The manifesto also contained a commitment to action on prescription charges, stating that:

> *Prescription charges are a tax on ill health and a barrier to good health for many people. They are also expensive to administer. An SNP government will immediately abolish prescription charges for people with chronic health conditions, people with cancer, and people in full time education or training. We will phase out prescription charges for the rest of the population by 2012.*

The party also made pledges about health inequalities, children's health and dentistry.

Despite the focus on independence, health did receive some attention in the campaign. An impetus to its importance in the election debate was given by an article in *The Scotsman* on 27 April, a week ahead of the poll.[19] It referred to the announcement the day before that Scotland's 67,000 nurses were not to get their full pay rise that month, despite a promise by the health minister. The previous day Dr Martin Wyatt, a consultant at Monklands Hospital in Airdrie, had spoken at a press conference organised by two fringe parties, Scottish Voice and NHS First. He had claimed that patients were dying needlessly in hospitals across Scotland because medical staff were stretched to their limit.

The Scotsman noted that health spending had doubled under devolution, but that Audit Scotland had frequently reported that there was scant evidence to show that the sums poured into the NHS had brought measurable improvements in performance. Figures obtained by the paper in March 2007 had shown that, since 1998, median waiting times for medical treatment had increased for 17 out of 25 common procedures. It argued that:

> *The real sickness at the heart of NHS Scotland lies in the Executive's strategy to close district hospitals and centralise care in a new breed of soulless super-hospitals. The result is bureaucracy, wasted resources and alienated patients, as well as breeding grounds for MRSA infection.*

The paper argued that the political parties must use the next few days to provide answers regarding the NHS. Could the policy of centralising medical delivery be reversed? Was there an alternative to expensive private finance initiative (PFI) contracts for hospital building, which had brought huge parking costs for staff and families? Above all, when were politicians going to stop using the NHS as a political football?

In the days immediately prior to the election, opinion polls showed the Labour party beginning to claw back the SNP lead. But on polling day, in an election marred by controversy about the design of the voting procedures and a large number of rejected ballots (the total of which, in a number of seats, exceeded the majority of the winning candidate) the SNP just held on to become the largest party, by a single seat, over the Labour party. However, its total of 47 seats was far short of the 65 needed to form a majority government. A significant feature of the election result, perhaps caused by the campaign focus on independence, was the virtual elimination of the independent MSPs and minority parties. Votes polarised around Labour and the SNP, with the Liberal Democrats losing ground and the Conservatives just about holding their own. A minority SNP government took power on 17 May 2007, with Alex Salmond being appointed as First Minister.

The Scottish elections of May 2007 produced another major change which perhaps has been less discussed outside the country. Local government elections were held at the same time as the national election, and used a new system of proportional representation (the single transferable vote). The combined effect of the new voting system and the swing against the ruling Labour party produced dramatic results.

By 17 May, the Scottish National Party was in a position of power, either on its own or in local coalitions, in 11 out of the 20 councils that had established ruling administrations. In contrast to the position at Holyrood, where the Liberal Democrats refused to enter a coalition with the SNP, the two parties had already come to agreements in six Scottish councils. The SNP was reported to be confident that when all 32 local authorities agreed leaders and provosts, it would have power in more councils than Labour. It had emerged as the largest party in terms of councillors in local authorities across Scotland, gaining 182 seats on its 2003 total, while Labour lost 161 seats.

4.6.3 The new SNP administration – first steps in 'joined-up' government

One of the topics which had been the focus of the monitoring activities from the outset was the extent to which the devolved administrations and their smaller populations would find it easier to deliver 'joined-up government'. This interest extended not just to the ability to tackle cross-cutting issues within central government, but to the ease of working between central and local government and the various non-governmental organisations. Previous

reports suggested that devolution did not of itself bring about easier joining-up across government, or more effective handling of cross-cutting issues. The impact of 'functional silos' had been reported as continuing to affect the operations of the different administrations, and the most recent set of interviews also confirmed this finding.

The 2007 elections in Scotland and the return of the minority Scottish National Party government were interesting from many perspectives, not least the attitude to the scale and organisation of government itself. Immediately on appointment, the new First Minister implemented a major re-structuring of the Scottish Executive, something that he had signalled prior to the election that he would require should he be elected. He wanted to cut back the size of government in Scotland, which he considered had become too large. In the words of *The Scotsman*,[20] "quietly, efficiently, without fanfare but with great care, the Scottish civil service has been transformed". The former nine executive departments, each of which had its own Minister, were immediately replaced by five new Ministers with the titles of Cabinet Secretary. The intention was to make these posts closer to the Secretary of State roles in the Westminster government, and each Cabinet Secretary has two or more ministers working with him or her. The five Cabinet Secretary portfolios covered health and well-being; education and lifelong learning; justice; finance and sustainable growth; and rural affairs and the environment.

Within the Scottish Executive, the five Cabinet Secretaries each had a Director-General reporting to them, with responsibility for one of five key strategic policy objectives set out by the new government These, according to the Permanent Secretary of the Scottish Executive, Sir John Elvidge, were focused on creating "a greener, healthier, safer, smarter and more prosperous Scotland".[21] The hope was that, by breaking down 'silos' in the public service, and making each Director-General responsible for specific areas of policy, the restructuring would ensure that there was more joined-up government in Scotland.

As well as responding to the political requirement for change, the reshaping of the civil service in Scotland also responded to a critical review of the way the former Executive worked. The *Taking Stock* report of December 2006[22] had found that the civil service in Scotland needed to urgently "increase the impact and effectiveness of leadership". The inspectors had been highly critical of the senior management, led by Elvidge. Their review found that both Executive staff and the organisations they come into contact with felt "that the senior leadership team lacks passion, pace and drive and do not perceive them as the powerful and unified driving force". Some changes had been introduced prior to the election of May 2007. The 14-strong management group that had been the Scottish civil service "board of directors" had been replaced by an eight-member strategic board, and in the new structure that board will consist of the Permanent Secretary and the five Directors-General. However, the latest reorganisation goes considerably further.

By itself, the ministerial changes do not reduce the size of government dramatically. The new administration had 18 ministers in all compared to 20 before the election. But providing the minority government could gain support for its proposals, the changes to the civil service would be only the start of a much wider set of changes in Scotland. Speaking in the Parliamentary debate on the appointment of his ministerial team, the new First Minister said Scotland did not need the nine departments of the Executive, 27

executive agencies and 152 quangos. "I am not sure we need that complexity for a nation of five million people. If you are going to have joined-up government you need less bits to join up." The combination of changes at national and local government level make the prospects for a new approach to joined-up working interesting. This should be a major focus of attention over the lifetime of the new administration, whether or not it manages to survive its full four-year term.

At the time of writing it is too early to make many predictions about the direction of health policy. Manifesto commitments may not be reliable guides, given that the minority administration will need to gain support for its programme of government on an issue-by-issue basis. Among the early announcements by the Health Secretary was an initiative on waiting lists that involves the scrapping of the so-called Availability Status Codes, which it claimed were unfair, lacked transparency, and led to people waiting for lengthy periods. The new First Minister also indicated very early in his tenure that he hoped to reverse some of the hospital closure plans.

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5. WALES

5.1 Introduction

Jervis and Plowden's 2003 report[1] contained a précis of the quarterly monitoring reports submitted by the Constitution Unit's Welsh monitoring partners. This noted that in the period concerned the health policy that had been pursued had been largely determined prior to devolution, with the commitment to tackle inequalities in health that had been set out in *Better Health – Better Wales* in 1998. The National Assembly for Wales had inherited an NHS that 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. In addressing the health policy agenda, Wales had wholeheartedly followed Westminster in its decisions to increase NHS spending. Areas of policy divergence from England were dominated by the Minister's decision to abolish health authorities, to centralise many of their activities and to devolve others to local health boards. Other areas of divergence were Wales' commitment to pursue the expected prioritisation of elective waiting lists and its commitment to extend free eye tests to vulnerable groups.

There was evidence that since devolution joint working between the NHS and other agencies had strengthened at ground level, but it was less clear that joint working had strengthened within the Assembly at policy-making level. The summary commented on the Townsend review of the Welsh NHS funding formula[2], which had proposed a dual approach to tackling inequalities in health. It had 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. Yet, although each independently recognised their potential role in tackling inequalities in health, there had been little communication during the review period between the various committees responsible for health and social care and economic development.

The National Assembly for Wales had inherited significant overspends by a number of health authorities in Wales, but these had been largely overcome as a result of significant increases in NHS spending. This had come both from the effect of the increased NHS spending at Westminster which had been reflected, via the Barnett formula, in the

Assembly's block grant, but also by the Assembly in its allocation of its block. The Health Minister had also recently made a commitment to wipe out deficits of the local health boards which were soon to be formed, which would mean that over time it would be difficult to judge to what extent financial management in the NHS has improved or deteriorated since devolution.

Even if devolution had not made the Welsh NHS itself more accountable to patients and the general public, it had made the Assembly more directly answerable to them, particularly through television political programmes and media focus on health policy. Individual Assembly Members were answerable to their constituents for decisions about the reorganisation or closure of health services in their local area, and this was making difficult strategic planning about the future location of acute and district and community services across Wales. Devolution had enabled the Assembly to put into place mechanisms for making health policy and for fostering a culture of consultation. It had also ignited a Welsh consciousness and a nation's sense of responsibility for its own health. But three years was not a very long time to see the results of devolved policy-making, so it was too early to see the full results of devolution.

Despite its new freedoms, the monitoring reports had noted that, on a number of occasions, Wales had found it necessary or appropriate to follow England's approaches almost to the letter. This was the case when a 'windfall' increase of £50 million announced in February 2002 had been committed to an expansion on spending on health services, although the money was not ring-fenced and arguably could have been spent either to boost the Welsh economy directly or to improve health through housing, transport or environmental initiatives.

It was also noted that, although several steps behind England, the National Assembly for Wales had opened discussions about the potential future use of private finance to fund capital development in the NHS. The Minister for Finance had reaffirmed the Assembly's commitment to public healthcare and, adopting what she called a 'Welsh way', had changed the term Private Finance Initiative (PFI) to talk of investment through public/private partnerships in Wales. It was argued that it might prove difficult for the Assembly to resist the PFI on ideological grounds if, over time, the publicly funded capital stock of Welsh hospitals began to look progressively shabbier alongside new, shiny, if costly, PFI hospitals in England.

Finally, there seemed to be a 'reality gap' between the optimism of the Health Minister and her ambitious commitments for service improvement, and the very real capacity and manpower crises being felt on the ground by healthcare professionals, trust managers and directors of finance in the NHS. Health service managers and directors of finance had warned that they might not be able to meet all the ambitious policy objectives of the National Assembly for Wales. The Welsh NHS was described as suffering from 'change fatigue', facing yet another major reorganisation which many doubted would bring the improvements promised by the Assembly.

5.2 Welsh health policy – the key building blocks

At the beginning of the period covered by this report, the Welsh NHS had begun working to implement the recommendations contained in the report *A Question of Balance* published in 2002.[3] This was the report of a review of capacity in the health service in Wales. It reviewed actions resulting from two earlier initiatives in 2000, the Capacity Working Group and the Emergency Pressures Task Force Reports, the changes which had taken place over the last two years, the pressures the service faced currently, and future trends. It commented:

> *The dynamics of managing capacity issues in Wales have changed since the last report, with real expectations by the Welsh Assembly Government for significant improvement in services. NHS Trusts must deliver continuous and sustained reductions in waiting times, whilst at the same time having systems capable of meeting emergency pressures. An unprecedented increase in growth monies has further heightened the expectations of the general public to see an overall improvement in their local services.*

Despite the improvements, the report revealed that most acute general hospitals in Wales were working with (unsustainable) bed occupancies of well over 90% in general medicine. The average number of patients awaiting their next appropriate phase of care was 806 per day across Wales during 2001/02, approximately three-quarters of whom occupied acute and community beds. (This had increased to an average 1,036 during the first five months of 2002/03.) At the same time, elective procedures were being cancelled because surgical beds were occupied by emergency medical patients or patients needing to be transferred to more appropriate settings. Unless the right balance could be struck between demand and supply, balance of emergency and elective workloads and the balance of resources in primary care, community, secondary, social care, independent and voluntary sectors, the whole system would work sub-optimally.

The report's recommendations were structured around eight key themes, within each of which issues for immediate or urgent action were identified, together with issues that should be addressed in the longer term. These themes were:

- Additional capacity was required across the whole system to meet rising demands and reduce unacceptable levels of pressure within individual sectors.
- Partners must work together to promote a whole systems approach to the management of demand and capacity, working to develop a better understanding of the interrelationships between demand, capacity and activity in each sector and organisation.
- Delayed transfers of care were a major cause of capacity problems within the hospital sector. Current numbers of delays could not be tolerated, and urgent action must be taken to significantly reduce levels.
- All sectors must demonstrate that existing resources were utilised efficiently and effectively.
- The patient pathway must be modernised, with innovative new schemes implemented to maintain patients in the community and divert admissions.

- Data collection within all sectors should be improved, both in terms of usefulness and accuracy.
- Workforce issues must be considered and new ways of working developed.
- Trusts and commissioners should consider implementing schemes or practices that have been shown to work well and which alleviate pressures on the system.

5.2.1 The review of health and social care in Wales (the 'Welsh Wanless' report)

The report of the independent, evidence-based assessment of the long-term resource requirements for the NHS that Derek Wanless had been commissioned to produce was published in 2002. *Securing our Future Health: taking a long-term view*[4] had concluded that both additional resources and radical reform were vital; neither would succeed without the other. He also argued that the level of success all wished to see was not likely to result unless the full engagement of both the public and the services was achieved.

Following the publication of the main report, the then Welsh Finance Minister announced in October 2002 a substantial increase in the future resources to be allocated to health in Wales. The 'Welsh Wanless' report, published in July 2003, reviewed health and social care in Wales, and assessed where the additional resources that became available should be directed. These were to be used not only to alleviate short-term issues, but also to seek the major shifts needed to balance demand and supply in the long term. The report was produced by a team including representatives from the Welsh NHS, the National Audit Office and the Welsh Assembly Government, advised by Derek Wanless.[5] It acknowledged the relatively poor health of people in Wales. Although rising resources and improving productivity were increasing the supply of health and care services, this was being outstripped by more rapidly growing demand. In his foreword, Derek Wanless commented that, generally, the position in Wales was worse than in the UK as a whole, reflecting trends evident over decades. He also noted that Wales did not get as much out of its spending as it should. In health this was placing unsustainable pressure on the acute sector and the impact extended into social care. Long hospital waiting lists and assessments without subsequent social service provision were the unacceptable consequences, and were symptoms of the deep underlying problems needing to be faced. The report confirmed the views of *A Question of Balance* that the current configuration of health services placed an insupportable burden on the acute sector and its workforce, the most expensive part of the system. Actions to reconfigure provision, release acute capacity and raise productivity were needed. There should also be a rebalancing of the system to meet need earlier in the 'care pathway', together with improvements in the way in which the parts of the system worked together.

Although health spending had risen substantially in absolute terms, and consumed a larger share of Assembly spending than in 1998/99, in every year but one since 1994/95, NHS organisations had reported deficits over £10 million. Cost pressures were increasing in social care, and there was significant variation in the level of spending, and

in its cost-effectiveness, between local authorities. Other areas of shortcomings included workforce planning, information and communication technology (ICT), and estates.

The conclusion, therefore, was that Wales was unlikely to achieve the main Wanless report's 'fully engaged' scenario for health without a sea-change in the quality and nature of its planning and capital and revenue investment. Although there was some good and some excellent performance in health and social care, there was also widespread under-performance, associated with systemic defects. There were not the performance management and incentive systems necessary to drive creation or adoption of best practice. The different areas of national policy-making needed to be better integrated, and the quality of information, and thus decisions based on it, was unsatisfactory at every level. Finally, health and social care organisations frequently found change difficult, particularly where it involved working across boundaries, and there were too few examples of successfully engaging the public in a change agenda. What was needed was a step-change in individuals' and communities' acceptance of responsibility for their health. Policy action was recommended to raise public awareness, supported by research to produce an evidence base into the gains which different sorts of action might yield.

The report recommended that the Assembly should stop funding deficits in NHS Wales. It should have stronger incentives and sanctions, which rewarded success, gave greater freedom to good performers, and were supported by the way in which resources flowed. Improved performance management was essential to raise standards across the board.

Other requirements identified included more sophisticated, robust and long-term workforce planning; training and retention of current staff; an overhaul of information systems, improving quality, timeliness and coverage, with ICT investment within a national strategy which embraced both health and social care; and major investment in estates.

To make the new organisational structures effective, clear and shared understanding was needed of national and local roles, and the relationship between national and local health, social care and well-being strategies. The accountability of NHS chairs and chief executives should be clarified and strengthened. The review argued that it would be important to chart and adhere to a programme of change which was realistic. Successful change would depend on leadership, energy and commitment from politicians, professionals, managers and staff alike.

The report stressed that it was essential to break down barriers between health and social care, not through structural change but through integrated thinking, across social care and health services, about achieving the best possible local outcomes together. There should be national standards for health and social care provision, so that both health and social care became national services, delivered locally. A redoubled effort was required to secure seamless provision, including consideration of options for finance, accountability, performance, policy and audit and local service delivery. There was a particular need to develop capacity within non-acute settings to support the delivery of new service models, and to involve patients and the public fully in debates about the future shape of service provision.

There was a case for viewing the prevention, health services and social care budget in the round at the Assembly level. Wales needed to focus investment on delivering health gain in the most resource-effective way. There was also a range of recommendations about making greater use of pooled budget powers; examining resources flows in health and social care systems to develop a system in which money followed activity, and a greater commitment to information and debate locally on the expenditure of public money, and the outcomes expected and achieved for the investment.

5.2.2 *Designed for Life*

The next major health policy development was *Designed for Life*.[6] Although the strategy proposed much that was new, it was built upon a policy direction set in 2001[7] to concentrate on delivering a healthy Wales through partnership. The strategy aimed to continue to improve health, and in addition accelerate improving health and social care. The major action underpinning the strategy was the development of a new planning system that would rapidly improve performance across Wales, ensuring the best use of all the talents and resources available, no matter where they were. The strategy recognised that this would "require a clear vision of where we are going, and the development of programmes to get us there" (p. 3).

A new vision was required, to describe what kind of health and social care services the people of Wales could expect by 2015. It aimed to:

- improve health and reduce, and where possible eliminate, inequalities in health
- support the role of citizens in promoting their health, individually and collectively
- develop the role of local communities in creating and sustaining health
- promote independence, service user involvement and clinical and professional leadership
- re-cast the role of all elements of health and social care so that the citizen would be seen and treated by high quality staff at home or locally – or passed quickly to excellent specialist care, where this was needed
- provide quality-assured clinical treatment and care appropriate to need, and based on evidence
- strengthen accountability, developing a more corporate approach in NHS Wales so that organisations worked together rather than separately
- ensure full public health engagement at both local and national levels.

The vision was to be delivered through a series of strategic frameworks, each covering three years. The published strategy would launch the first framework, after which at the start of each subsequent stage a 'fit-for-purpose review' would take place to assess progress and ensure that the most effective approach and structure was in place. The three-year framework would provide the context for individual organisational and functional strategies, and the three-year cycle would define the progress to be achieved and strengthen performance management and accountability. Each cycle would be formally evaluated.

The first strategy published covered the period 2005 to 2008 and was focused primarily on the vision for health services and health improvement. This period would be one of the most critical and challenging for the health and social care services in Wales, with a focus on redesigning the system to meet the objectives set out in *Wales: a better country*, the strategic agenda of the Welsh Assembly Government[8] and *Making the Connections*, the Welsh Assembly Government's vision for public services.[9] It would:

- set stretching targets for the NHS that would challenge the service to change through a combination of investment and modernisation
- concentrate on redesigning the provision of healthcare, using available evidence of effectiveness, and seeking evidence where it was lacking
- drive forward work already begun on managing demand
- maximise the benefits from information and workforce developments
- reduce waiting times for patients and clients, so that Wales would be broadly in line with the rest of the United Kingdom by 2009.

As a result, services in Wales would be much more 'balanced' than before – enabling further improvements to be realised.

Its targets represented a first stage in the process – and would prompt a sharp shift towards:

- preventing problems rather than waiting for them to occur
- improving access to all elements of health and social care
- better designed, better delivered services in key priority areas – cancer, coronary heart disease, chronic disease and long-term conditions, mental ill health and services for children and young people and for older people.

Numerous other policy initiatives were introduced to address specific conditions or policy areas, and in public health these included the ban on smoking in public places.

5.3 Where is the Welsh health system now? Views from the health service

What had been the effect of all these policy initiatives? What did all this add up to by early in 2007?[i] Respondents to the interviews reported many favourable developments, but in nearly every case these were tempered with concerns about problems, difficulties and challenges which remained. The overall balance, positive or negative, tended to depend on where people were placed in the system. In general, service providers tended to see more challenges and more 'unfinished business' than did those in the 'policy elite'.

There was an extensive list of positive developments. These included a degree of confidence that a distinctively Welsh approach was being adopted. One respondent commented that there was a confidence that they were following a Welsh approach, "not

i The majority of the fieldwork was done in March and April 2007, before the campaign for the 2007 Welsh Assembly elections got underway.

an English one five years after the English". Another described the success as creating something "consciously Welsh and different". While the ability to have a distinctly Welsh approach was a strength, it had an associated weakness in that people spoke sometimes of unnecessary antipathy to approaches emanating from England or elsewhere, which might be rejected unnecessarily. "'It has to be done this way in Wales because we are different' becomes a defence mechanism." The feeling was that in Wales there was a greater corporate sense of the NHS than there was in England. Comparisons with England were made often, even when the questions asked did not prompt such comparison. Indeed, one respondent described Wales' success in terms of "having little of what is going on in England". There was much enthusiasm for *Designed for Life*, which was seen as giving direction to the health strategy. There was, in the words of one respondent, a "start less, finish more" emphasis around.

What were considered to be the successful ingredients of the Welsh approach? These included a determination to tackle inequalities, which people considered had been reduced through a combination of devolution and the strategic use of European Objective 1 funding. Economic regeneration was seen as one of the country's successes, with Wales enjoying its highest level of employment ever. "The Assembly has done heroic things on getting investment into Wales," was one comment. This worked through directly to the addressing of inequalities. Another key ingredient was the ability to maintain a focus on public health/health of the population as well as addressing issues within the health services such as waiting lists. The former was aided by early linkages between health and social care; investment in public health as a profession and the maintenance/development of a central public health service; and strong links between local government and health.

As in Scotland, in assessing achievements, people admitted that they were judging as much on potential as on the reality. Asked to mention specific achievements in the period since devolution, people did not find it easy to produce a long list. Work on children's services and the appointment of the first Children's Commissioner, initiatives on eye tests and prescription charges, and (at the time) the forthcoming smoking ban were noted as achievements.

Issues of culture and continuity were also seen as important. A frequent observation was that much of the current policy focus was a continuation of the Welsh work on health gain first developed in the 1980s. It was noted that a number of the key people responsible for that work were still involved with the Welsh health system. There had not been the same 'churn' of senior executives or the degree of organisational change experienced in England. The trusts had been largely unchanged since the start of devolution, and many of the senior management cadre were unchanged. There had been in Wales only two health ministers since devolution (at the time of the interviews).

A particular feature of the current system was that there was now a stronger voice for parts of Wales other than the South East. "We don't stop devolution at Cardiff." Localism was very strong and local government had been one of the key entities, reflected in the choice of Local Health Boards (LHBs) that were co-terminus with local authorities. It was

also noted that there had been an ability to resist reorganisation, even when people recognised that the structures existing were not ideal.

> *The health service was worried that commissioning was being done on areas that were too small. But they had made the decision not to restructure. "Let's try to make it work."*

There was a well-articulated vision of what public service should be about, in which context the 'clear red water' speech of the First Minister at Swansea University in December 2002 was frequently cited, together with the focus on citizen engagement and the ideas promoted by Beecham. There was a shared understanding and a degree of comfort with the ideas, which were a continuation of an existing belief system in the face of approaches using competition and market systems. The First Minister was described as having the view that the Welsh would not accept the social market economy, and that they wanted excellence in the public sector, not competition. There was not felt to be the same threat of the private sector as there was in England.

It was also noted that, in resource terms, Wales had *relative* stability, not the feast/famine/feast of elsewhere – although this did not mean resources had been adequate. Despite the increased funding of recent years, people expressed a view that Wales received a worse deal than England, and they questioned whether the health service got the full 'Barnett uplift'. Many had the perception that Wales was disadvantaged compared to England, particularly in terms of capital. Overall, the judgement was that the direction of travel was good, even if more achievements were needed. It was also expected that the Government of Wales Act would enable things to be done faster.[ii]

5.3.1 Governance and accountability

As in Scotland, respondents commented on the way in which the Assembly was maturing in the way in which it operated, and how the politicians within it had gained more experience and confidence. The political leadership in the country given to the health agenda was widely acknowledged. To some, this contrasted with a lack of leadership in some parts of the health services.

> *The language and distance created (i.e. from the English) comes from political leadership.*

> *It helps to have a First Minister of experience and stature. It gives confidence to be different.*

The First Minister had been a strong, powerful advocate for 'upstream' approaches to health, housing, the environment, jobs, etc. Nevertheless, there were downsides, many of

ii The 2006 Government of Wales Act involves separating the roles of ministers and the Assembly itself. As a result, from May 2007, the current executive powers of the National Assembly for Wales became the responsibility of the Welsh ministers, who would form the Welsh Assembly Government. The role of the National Assembly for Wales becomes to scrutinise and monitor the Welsh Assembly Government. The Act also introduces the ability for the National Assembly for Wales to make its own legislation on devolved matters such as health, education, social services and local government. The Act also includes provisions that enable the National Assembly for Wales to hold a referendum to ask the people of Wales whether the Assembly should have full law-making powers like the Scottish government.

which related to the difficulties of tackling unpopular or controversial decisions. These difficulties, referred to in previous reports, were still present, and a number of particular examples were cited.

> *The politicians want a step change, but when it comes to it they back down on issues like out-of-hours services, accident and emergency services, etc.*
>
> *Strategic reconfiguration problems have been made worse by parish pump politics.*

There was disappointment about what some in the service saw as the overt politicisation of issues. In one of the recent examples cited there was what people described as very strong medical/clinical advice about the way forward. However, the Health Minister did not act on it but instead called for another independent review. By the time that had been completed, Wales was in the pre-election period. So people consider the issue effectively had been 'kicked into touch'. Another interpretation offered was that the minister, a politician, had trumped the medical advice with political realities. Perhaps this was to be expected, because some had estimated that implementing the recommendations before the elections might have cost Labour up to six seats. This, and other cases like it, continued to demonstrate the difficulty in the devolved administrations of addressing controversial issues, and the added complications caused what is effectively a two-year electoral cycle when both Assembly and Westminster elections are taken into account.

The 2006 Government of Wales Act was seen as a very significant and welcome development which was expected to enable the Assembly to be more busineslike. The new arrangements, in effect a parliamentary system, were expected to enable ministers to take decisions more effectively and argue their cases with the Assembly. They offered the chance to have different ministerial portfolios and committee structures, perhaps with 'thematic' committees on, say, children, older people. The committee chairs were expected to play important roles in holding the ministers to account.

One of the issues which perhaps most disappointed respondents was the perceived lack of progress with delivering better 'joining-up' in government and tackling the 'silo' mentality in the administration. The potential of the smaller devolved administrations to deliver better joined-up government was highlighted in the earlier reports, and identified as a key focus of monitoring exercises. The judgement of those interviewed in the spring of 2007 was that, to date, the Welsh Assembly Government had failed to crack the problem of silo management. In fact some felt it may even have become harder to tackle cross-cutting themes. It was said to be hard to get issues of cross-cutting relevance understood, and this affected areas like health research and development, where investment could result in a significant impact on health, wealth, social justice and education. When it was possible to get all the ministers concerned to address issues like this it did have huge benefits, including in negotiations with UK research bodies. Various steps were being taken, including the introduction of a 'policy gateway' process that was considered promising, but the results had not yet worked through. The difficulties were not only with the policy formation stage, but also lay with the ongoing management of programmes.

It was widely recognised that the current structure of 22 local health boards was probably not the best way to organise. Some argued that in a small country it was hard to find the leadership for these, and the structure caused a real problem with the integration of services. For example, in Swansea, the Health Trust negotiated directly with four local health boards. When trying to reconfigure services across local health board boundaries, for example surgical services and some tertiary services, there was no strategic overview across a wide area. Clinicians had expected that the 'regional offices' of NHS Wales would play a greater part the planning of such services, but these expectations had not yet been met.

Despite the commitment to partnership working between the Assembly and local government, those in the health services still reported difficulties in working with local authorities, and considered that health and social care did not work as well together as they should. Local authorities were sometimes reluctant to yield or share sovereignty, and were used to working in a scrutiny mode rather than a problem-solving one. It was a partnership of organisations that had no culture or track record of working together. Although the media were constantly debating health and education issues, the coverage was described as 'middle of the road' and not particularly aggressive. The local media in Wales were thought not to be as powerful as their counterparts in Scotland and Northern Ireland. The media approach was influenced by the strong Welsh belief in healthcare and the Bevan legacy. Thus "Goodness persists even if/when there are individual bad stories."

Accountability was central to issues of finance, resources and financial management. There was a feeling that some of the longstanding financial difficulties in different parts of the service still had not been finally resolved. Earlier plans to write off the deficits of local health boards were reported not to have been implemented, and deficits had been masked in different ways. Despite the 'Welsh Wanless' review, financial problems continued with some boards facing deficits and potential overspends, placing the organisations under stress and presenting them with impossible targets. While *Designed for Life* was supposed to be the answer to structural and financial problems, it was noted that it had not been accompanied by any detailed financial analysis.

5.3.2 The relationship with England

Relatively few tensions with England were reported, although somewhat more with the Department of Health when acting in its UK role. At the time of the interviews, respondents felt that there were few signs that the relationship could become as fraught as Scotland's might possibly become were there to be a government of a different political colour in power in Edinburgh. There were a variety of reasons for this.

Wales felt reasonably isolated from key initiatives in England. In part this was because the English were felt to have "given up noticing the differences" and were more relaxed about divergence. It was also in Wales' interest to keep informed of what England was doing in order to learn, because in many areas they just did not have the capacity to do

things for themselves. There were some initiatives where Wales waited then followed, for example the broad strategy of cancer screening. There were also areas where Wales was trying to lead, for example on e-health, where opinion was that the Welsh strategy was better. Wales had its own national service framework and national standards. They also had concordats with the Healthcare Commission and NICE. Some commented that the Welsh Children's National Service Framework was better than the English.

There were still concerns if and when it looked as if English developments might have knock-on implications for Wales, although in theory the new Government of Wales Act would be able to ameliorate such difficulties. An example was the developing English thinking about cities and regions, which could not be extrapolated to Wales because for the most part it did not have the big metropolitan regions that existed in England. Respondents described how many of the UK bodies, such as the Environment Agency, the ESA, the General Medical Council and the Postgraduate Medical Education and Training Board were having to adjust the way they worked in response to the arrival of the Welsh Assembly Government. The GMC Welsh office was identified as one innovative pilot scheme.

Perhaps the biggest difficulties came with personnel and manpower issues, such as the consultant contract and the GP contract. Although contributing to the negotiations, Wales had broadly the same contracts as England, despite often very different requirements. As a result people were questioning how long this would be tenable. The recent review of professional regulation by Donaldson had caused irritation with its references to structures that did not exist elsewhere than England, although the recommendations themselves did not raise many issues for the Welsh. The way the resulting White Paper more clearly allowed freedoms for the devolved administrations was welcomed. The Foster report was regarded as having handled the involvement of the devolved administrations much better than Donaldson had done.

Looking to the future, one issue was about the demarcation between particular UK-wide roles and that for England, particularly when these were discharged by the same person. The role of the UK Chief Medical Officer was a case in point. Respondents asked how the four CMOs should work together, and whether the UK role should be shared or more clearly delineated. Should particular CMOs lead on different issues when these either related to the situations in their own administrations or reflected their personal specialisms? Future development of thinking and practice about these roles would be needed.

In general, the role or salience of UK-wide bodies had not visibly expanded in Wales as devolution grew. "All the key organisations still seem to circle around Westminster – and this can be unhelpful." Moves like the creation of a combined Medical Research Council and Wellcome research budget had major implications for Wales, but these were often unrecognised. Respondents argued that nothing should be done which might increase the isolation/separateness of Wales. It would be far better to engage with all-UK bodies, provided they did not allow their agendas to be dominated by England.

5.3.3 Wales' international aspirations

Wales naturally looked to the 'Celtic fringe' for links and comparisons. But, as one commented: "Wales has still not left home, while Scotland feels it has full independence."

Relatively little discussion in Wales about European developments was reported. If there was any debate, respondents thought, it might only have involved very senior levels in the administration. "Europe isn't on the medical agendas", was one comment. The Bologna agreement and its impact on the international flow of doctors was very important, but "not on the radar in organisational terms". There seemed little interest in EU cross-border patient mobility initiatives. As one respondent commented: "It is bad enough sending people to Weston super Mare, let alone Europe." There is a possible paradox here, because in terms of its economy, regeneration and competitiveness agendas, Wales' aspirations are strongly international. But this does not seem, for the most part, to be reflected as strongly in its approaches to health systems and policies.

5.3.4 Reflections

The views revealed in the fieldwork echoed many of the conclusions of a bigger survey conducted in 2006 by the Institute of Welsh Affairs with eight different policy groups.[10] Its analysis concluded that if Wales was serious about ensuring that the NHS operated as efficiently as possible, the problem of closing inefficient hospitals across Wales was going to have to be tackled. The report argued that in some respects the Assembly Government had been its own worst enemy in promoting hospital reorganisation. Adopting a citizen-based approach and stating that a "determination to find out what patients want will underpin the process of continually improving our services", as it had done in its 2001 strategy, made it difficult for a minister to go against the wishes of people who wanted to keep their local hospital open, even when available evidence made it clear that so doing would be highly inefficient.

If the concerns relating to the sustainability of the NHS, as stated in the Wanless report and which *Designed for Life* had sought to address, were not to materialise it was essential that people's expectations of the role and functions of hospitals should change. The Assembly Government had a major responsibility to direct such change, ensuring at the same time that appropriate community-based services were in place to remove the present necessity for many people to use acute hospitals. The overall assessment was one of 'qualified optimism' for the period after the elections. People recognised a number of 'false dawns', but argued that from now on failures could not be afforded, nor could there be new policy frameworks, or shifts in belief and activity. What already existed must be driven through. Issues of leadership and courage were central to this, particularly political leadership.

5.4 Welsh attitudes to public services

The most recent surveys[11] indicated that health services were the most highly rated public services in Wales, both among patients and the population generally. Satisfaction ratings appeared to be broadly on a par with the rest of Britain. Health services had the highest levels of net satisfaction[iii], in common with Britain as a whole.

Table 5.1 Net satisfaction with local health service providers

Base: all respondents (1,010)	**±%**
GP	+80
NHS overall	+65
NHS hospitals	+60
Ambulance services	+41

Source: General Public Satisfaction with Public Services in Wales Survey, 2006

Ratings for the NHS overall appeared to be high compared to the rest of Britain, which had a net satisfaction score of +45 percentage points in the latest Department of Health Tracker research. Welsh residents also seemed happier with their local doctor: while the net satisfaction score for Britain was +71, that for Wales was +80. Taking methodological considerations into account, it was probable that satisfaction with public health services was on a par with the rest of Britain. However, when asked for their views on service provision, more residents thought that the NHS (along with policing services) would deteriorate over the next 12 months – in this respect, attitudes mirrored those across Britain as a whole.

The Welsh Institute of Health and Social Care 2006 health barometer survey of leadership opinion in NHS Wales[12] identified ten key messages. These included that:

- there was a strong feeling that the NHS was moving forwards
- many short-term targets might be missed
- the Welsh Assembly Government should give greater priority to
  - developing commissioner competencies,
  - strengthening GP-led/primary care services
  - following best practice in diagnosis, treatment and care.

The comparisons with England were mixed, with the links between the NHS and local government, and the management of NHS finances being considered better in Wales than England whereas planned hospital care and mental health services were considered better in England than Wales.

iii The percentage of satisfied respondents less the number of dissatisfied respondents. The figure can therefore range from plus 100% to minus 100%.

Morale among managers had declined, but most respondents still wanted to work in Wales. Local partnerships were improving slowly. Comments about *Designed for Life* included:

- it set the right direction, but neglected some of the key issues
- its waiting times targets would probably be met, but other key targets were looking doubtful
- there was doubt among NHS leaders about the commitment of politicians and local government to achieving it
- re-structuring of trusts and LHBs should be on the agenda
- the regional tier of NHS Wales should be developed
- the public did not get a well-balanced view of the NHS from the media.

5.5 Health in politics and the Welsh Assembly election 2007

In the 2007 election campaign for the Welsh Assembly, the Welsh Conservatives committed themselves to providing a first-class NHS, free to all. They stressed they were committed to improving the NHS for everyone, rather than helping the few opt out, and they ruled out any move towards an insurance-based system. Their vision for the NHS and healthcare in Wales was for trusts, doctors and nurses – not politicians – to be in the driving seat, so that they could decide what was best for their patients. This meant:

- local GP services available when needed
- safe and speedy access to hospital services which should be local wherever possible
- help when needed to remain independent, at work and at home
- an end to long waiting lists
- access to modern medicines that doctors wanted to prescribe
- effective services for looked-after children.

On hospital services, the Welsh Conservatives argued that the NHS should not be a political football and that change and development should proceed on the basis of consensus. Advances in medicine and greater specialisation made new ways of working necessary. Welsh Conservatives would establish a special commission to examine the structure of hospital services. Each political party would be asked to nominate a commissioner, as would key stakeholder groups such as the BMA, RCN, patients and carers, and community health councils. Specific commitments included using the capital budget to develop intermediate care through the network of community hospitals in Wales; encouraging NHS trusts to seek Foundation Hospital status and allowing a measure of financial autonomy to such trusts; and reviewing the delivery of health services in rural areas to ensure the highest level of access to modern services.

The Welsh Conservatives also committed themselves to ending the 'Berlin Wall' between health and social care by establishing unified care agencies. These would be:

- based on local authority areas to provide primary and community healthcare and adult social care

- funded by a ring-fenced grant from local authorities
- accountable to the local authority, but at arms-length in operational matters.

The party would replace the 22 local health boards with an all-Wales commissioning body, which would develop secondary and tertiary health services. GP practices would play a direct role in the commissioning of secondary services. The operation of cross-border working between NHS organisations in Wales and England would be reviewed.

The Welsh Labour Party promised to:

- continue to provide all NHS prescriptions free of charge
- ensure all children had an opportunity to use a sports or leisure facility or swimming pool free of charge at weekends
- improve the quality of food in schools, hospitals and other public premises, and provide increased investment in school kitchens
- ensure that all people who want one could have access to an NHS dentist
- provide free parking at NHS hospitals for patients requiring treatment for chemotherapy, radiotherapy and renal dialysis, including season tickets for those who wanted them
- further reform charging for home care services, making 10,000 disabled people better off and exempting 4,000 disabled persons from all charges.

The Welsh Liberal Democrats pledged to bring healthcare and well-being services together through Health Hubs which would provide a whole range of patient services in the community. They would remain committed to a network of District General Hospitals providing accident and emergency and Maternity Services as close as possible to the patient's home. Alongside this they aimed to develop the role of community hospitals in providing diagnostic, recuperative and rehabilitation care. They would protect services in rural areas, where closures would lead to excessive and potentially dangerous travelling times. They would guarantee stability for healthcare providers and patients by ruling out another expensive and unsettling NHS reorganisation. Instead, they would encourage greater collaboration and cooperation. They would require LHBs to work together on secondary commissioning and would encourage them to merge where appropriate.

Where appropriate, they would provide financial incentives for organisations to work more closely together and introduce a shared budget between NHS and Social Services to deal with delayed transfers of care. They made various commitments to simplifying and stabilising the funding process for Charitable and Voluntary Organisations working with the NHS to provide services. There were a number of commitments to improve the quality and quantity of dental services, to provide better representation for patients in NHS decision-making processes, to provide support for carers and to encourage healthy living.

Plaid Cymru's manifesto talked of the NHS and the focus of Government needing to evolve to deal with 21st-century healthcare challenges. Its aim in government would be to develop a health service rooted in communities which was as much about promoting well-being as about tackling illness. Plaid placed particular emphasis on developing a

national Children's Health Service, including provision of one school nurse for every secondary school and associated primary schools; setting up a school-based dental service; directing more resources towards physical education; and making a significant investment in mental health services for children and young people.

For health services, Plaid committed to investing in a network of state-of-the-art primary care and walk-in treatment facilities in communities, managed in the first instance by local health boards. As well as improving general access to the NHS, the well-being centres would alleviate pressures currently seen in hospitals. Targeting chronic conditions through disease management and prevention would be central to the work of well-being centres. The manifesto commitments also included placing a new requirement on employers to provide occupational health schemes and actions to improve mental health services. A Plaid Cymru Government would call for all powers over mental health to be devolved to the Assembly through an Order in Council. There was a commitment to "stopping the hospital closure programme in its tracks", as current proposals contained little detail on how they would improve access to NHS services or how community services would be developed.

The party recognised that, as part of a programme of improving services, change was inevitable. In government its aim would be to develop community, general hospitals and specialist services. It would create a Patients Rights Contract setting out the protected core services that must be made available within any locality, and ensure that bodies making decisions on any further reconfiguration proposals were locally and democratically accountable. The contract would also, for the first time, create a system for no-fault pay-outs if patients receive substandard care. Other commitments were to establish a National Institute of Health Research to focus on medical research in chronic disease and to introduce initiatives to tackle delayed transfers of care by requiring local health boards and local authorities to share their budgets. This would be the first step towards the creation of a single seamless tier of joint health and care authority. Other initiatives promised included action on palliative care and the support of carers.

Plaid Cymru also made clear commitments on free care, stating its belief, in principle and as an aim, in securing free care provision for older people and disabled people. It said that in the short term it would immediately cap the charges local authorities were able to raise for care; raise the savings thresholds for contributing towards residential costs; and create benefit take-up teams in every local authority to ensure that older people and disabled people received benefits to which they were entitled. It would demand the necessary powers to create a National Care Fund financed through a proportion of the revenue received as part of its proposed local income tax.

The election campaign itself featured a nationwide health campaign by the Welsh Conservatives against Labour's planned NHS 'cuts', targeting local communities threatened by a loss of local services. Launching the campaign, the Conservatives' Assembly health spokesman Jonathan Morgan said that, instead of cuts, the Tories would engage in a "proper dialogue" with local clinicians and people on local services.

Plaid Cymru also focused their election campaign on health services, claiming that Labour had failed to deliver on their NHS pledges. The party's health spokesman launched a mini-manifesto to save the health services, and the Welsh Liberal Democrats also highlighted their campaign against NHS cuts. The party leader Ieuan Wyn Jones said, on the last day of campaigning, that his first act would be to stop an on-going hospital shake-up.[13] Hospital closures dominated much of the campaign, with anxiety in many key constituencies about the future of local health services.

The rhetoric and the pledges from the different parties was an uncomfortable reminder of the difficulty the Assembly has had in making difficult decisions. In the election, the Labour Party lost seats and lost its majority in the Assembly. At one stage it seemed that the Labour Party would lose power to a 'rainbow coalition' of the Liberal Democrats, Plaid Cymru and the Welsh Conservatives, but the three parties were unable to deliver such a coalition. After some delay, a Welsh Labour minority administration took power. However, faced with the problem of leading a minority government, in June 2007 Welsh Labour and Plaid Cymru negotiated the formation of a coalition Government. The two parties published a 'progressive agenda' for government of Wales on 27 June 2007.[14] The agreement contained proposals covering all major policy areas. The section on health included a statement explicitly rejecting the use of privatisation of markets in healthcare:

> *We firmly reject the privatisation of NHS services or the organisation of such services on market models. We will guarantee public ownership, public funding and public control of this vital public service.* (p. 8)

The agreement promised a new approach to health service reconfiguration and pledged that the people of Wales would be fully engaged in any future reconfiguration of services. There would be a moratorium on existing proposals for changes at community hospital level, and changes in district general hospital services would not be implemented unless and until relevant associated community services were in place. It would revisit and revise proposals which reconfigured individual services through single-site solutions and it would:

> *reinstate democratic engagement at the heart of the Welsh health service by putting the voice of patients and the public at the centre of what we do. We will reform NHS trusts to improve accountability both to local communities and to the Assembly government.* (p. 9)

Other pledges included:

- making changes to the way in which consultation was conducted
- resolving to keep the NHS publicly owned, funded and managed
- moving purposefully to end the internal market.
- eliminating the use of private sector hospitals by the NHS in Wales by 2011
- ruling out the use of Private Finance Initiative in the Welsh health service during the third term
- ending competitive tendering for NHS cleaning contracts.

There were also a number of pledges about waiting times and access, maintaining free prescriptions, improving patient experience and supporting social care.

Given this, continuing the implementation of the *Designed for Life* strategy and the hospital reconfiguration plans appear to pose major challenges for the new health minister, and it will be interesting to see what effect, if any, the new structure of the Welsh Assembly Government and its processes has on this.

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6. ENGLAND AND THE UNITED KINGDOM

6.1 The English regions and London

The main focus of the Nuffield Trust's various devolution and health initiatives has been on the impact on health policy and the health services of the new freedoms stemming from political devolution. As a result of the way that the UK's approach to devolution has developed, the Nuffield Trust's series of devolution and health monitoring reports have tended to focus on developments in the administrations in Northern Ireland, Scotland and Wales, developments which have had significant implications for what formerly was the 'UK NHS'. The implications of the changes for bodies with UK-wide remits, such as many of the Royal Colleges, have also been investigated. Less attention has been focused on the English NHS because, in devolution terms, there has been less to monitor. The work for this updating report followed the same overall pattern.

But of course there has been massive change within the English NHS over the period from 1998. It is one of the ironies of the asymmetric devolution that now exists within the UK that none of the developments within the English health system in recent years have been the direct result of political devolution to England and – with one exception – none have been the result of political devolution within England. At the outset of the UK's devolution 'experiment' it had been expected that by now plans would be well advanced to introduce political devolution of some powers to the English regions. Referenda on the introduction of elected regional assemblies were planned to be held in three English regions in November 2004: the North East, the North West, and Yorkshire and Humberside. In the event, the latter two votes were delayed because of concerns about the security of the all-postal voting system proposed. However, the North East referendum did go ahead on 4 November 2004 and the proposal for an elected regional assembly was rejected by 78% of the electorate, in a poll with a 48% turnout. Four days later the Government announced the cancellation of the other two referenda.

Since that time, the regional political devolution agenda in England effectively has been on hold. It has remained the government's policy to devolve power, wherever feasible, to what is believes is the right level. Options for devolution to regions and major cities were outlined in the Local Government White Paper *Strong and Prosperous Communities* published in November 2006,[1] and were then the subject of a joint review of sub-national economic development which was being carried forward by the Department for

Communities and Local Government, HM Treasury, and the Department of Trade and Industry. The aim of this was to establish how the Government "can best devolve powers and resources to regions and local authorities in cities and elsewhere to ensure there is clear accountability for decisions; stronger leadership and incentives to enable and support growth; reduced inequalities; and effective governance arrangements".

The only exception to this general situation within England, where political devolution is concerned, was the creation of the Greater London Assembly, the developing role in health of which had been covered in the Nuffield Trust's previous monitoring reports. In London, the Mayor and Assembly have continued to develop their respective roles in the past four years. There was a full consultation on the future strategic governance of London, launched in November 2005. This resulted in a Government announcement on July 2005 of an enhanced package of powers, covering new lead roles for the Mayor on housing and adult skills in London; a strengthened role over planning in the capital; and additional strategic powers in a wide range of policy areas including waste, culture and sport, health, climate change and appointments to the boards of the functional bodies. The package also enhanced the ability of the London Assembly to scrutinise the activities of the Mayor. The new package included two commitments in respect of health:

- the Mayor would prepare a strategy to tackle London's health inequalities and promote the reduction of health inequalities in London.
- the Regional Director for Public Health in London would act as Health Adviser to the Mayor and Greater London Authority Group.

The second commitment reinforced the situation that in fact had existed since the creation of the GLA, and which had been discussed in the Nuffield Trust's earlier monitoring reports. Although these changes strengthened the ability of the Mayor and Assembly to address the wider determinants of health, they continued to have no direct powers over health services' organisation or governance.

6.2 English health policy[i]

England accounts for around 85% of population of the United Kingdom. Running the English NHS therefore involves running an organisation many times the size of that in any of the devolved administrations. Not surprisingly, therefore, problems of size and scale have featured prominently in discussions about the most appropriate organisation and structure. Even if there was no difference in the philosophies and values of the various governments (which, of course, other Nuffield Trust projects cited elsewhere in this report indicate that there are) considerations of scale and size alone might force differences in approach between England and the devolved administrations. In fact, the growing differences between the English NHS and the others reflect the effects of both political philosophy and scale.

i For the reasons discussed above, the scope of this report does not extend to a detailed account of the changes in English health policy and health services. These have been much discussed by other commentators.

For the past four years, English health policy has continued on the trajectory established by the NHS Plan published in 2000, the main drivers of which were discussed in the 2003 report. It has not been an easy journey! The philosophy behind the Plan was summed up by a former Secretary of State for Health.

> *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.*[2]

The policy rhetoric in England has been sharply different from that in Scotland and Wales, and major features of the organisation and governance of healthcare now differ between the countries. Patient choice was placed at the heart of the English reforms, with the intention that patients should be 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 in 2001. As the English NHS capacity grew, 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. There was a commitment to new Private Finance Initiative (PFI) mechanisms, joint venture companies and the involvement of international providers.

These principles have continued to determine the development of English health services policy over the past four years. English policy, therefore, has been a proving ground for the government's philosophy towards public services, and it has embraced the various strategies discussed in more detail in the following chapter. This has seen the application, in the health services context, of the themes of 'personalisation', choice, and diversification of the supply side. The further implementation of the English health strategy outlined in the NHS Plan has been delivered through a number of White Papers, including:

- *The NHS Improvement Plan: Putting Patients at the Heart of Public Services*, published in June 2004, which set out priorities for the NHS for 2004 to 2008
- *Creating a Patient-led NHS: delivering the NHS improvement plan*, published in March 2005
- *Health Reform in England: update and next steps*, published in December 2005
- *Health Reform in England: update and commissioning framework*, published on 13 July 2006.

The period has also seen the publication of a public health White Paper *Choosing Health: making healthier choices easier*, published in November 2004, and of proposals to increase public and patient involvement in *A Stronger Local Voice: a framework for creating a stronger local voice in the development of health and social care services*, published in July 2006.

As is well documented elsewhere, despite the very significant increase in funding as a result of the Wanless review, by 2006 the English NHS faced severe financial difficulties. Staff cuts and other emergency measures were needed to bring the service back into financial balance, something which was achieved by May 2007. Partly as a result of financial pressures, but also because of changes in approaches to services delivery, the English NHS faced the need for significant service reconfigurations. This prompted the newly-appointed Chief Executive of the NHS, David Nicholson, to write to all English MPs in November 2006.[3] He argued that the NHS at a local level was responding to a number of drivers for change by developing a new model of care.

> *Put simply, this can be described as providing care closer to people's homes where appropriate, with centres of excellence for more specialist care where clinically necessary, both complementing the services of District General Hospitals.*

As a result, more care would be conducted outside the four walls of hospitals, and when people were admitted to hospital, more and more procedures would be carried out as day cases. While the changes were positive for patients and their carers, they would have an impact on the numbers of beds required by acute hospitals and on where and how NHS staff worked. The need was not to preserve the status quo, but to think imaginatively about how to unlock resources, both in terms of money and people, to redirect them where most benefit can be achieved for patients. Nicholson argued:

> *The NHS has a duty to respond to the changes that technology, skills, patient needs and resources are driving. These are not easy or simple decisions to face up to. If the NHS lacks imagination or courage, then it will revert to a series of quick fixes, rather than seizing the opportunities there are to transform the provision of care.*

He guaranteed that any service changes would be a matter for local decision-making, and subject to consultation and independent scrutiny.

The English NHS thus entered 2007/08 with a major challenge of service change and reconfiguration. Any service changes locally were likely to be strongly resisted, as they have been in the devolved administrations. Delivering successful reconfiguration will be a test of the English NHS's governance arrangements, a test which is likely to come at a difficult time politically, with the new Brown government facing a general election in 2009 or 2010.

6.3 The directions of divergence

If there is divergence between the different members of the UK's family of health services, one key question is who is diverging from whom. In developing a detailed 'map' of devolution and divergence, Smith and Babbington[4] comment that if 1998 provides the

baseline for departure from the UK NHS, it is England that has moved furthest. They develop their analysis using two dimensions to plot the position of the different countries. One is 'left–right', which differentiates between the state paying, providing and managing services and the use of the full diversity of provision, private financing and consumer services. His second dimension is labelled 'unionist–nationalist' and reflects the extent to which the UK Parliament and Secretary of State determines priorities, policy, national budgets and performance management versus national determination of priorities, policies, raising income and allocating resources.

Ham (2004)[5] divides the differences between health systems into divergence in NHS structures on the one hand and systems of national government on the other. The divergences in structure are driven by the various national white papers. The different political governance arrangements have resulted in differing power relations between politicians and civil servants, with concomitant effects on the ability of the devolved national health services to respond to local (i.e. national) wishes.

Smith and Babbington conclude that the English NHS has moved significantly towards the right on the first axis, towards provider diversity and consumer choice, but with little movement on the unionist–nationalist axis. Ham similarly cites the tendency in England towards more market-based solutions, something also described by Greer and Rowland.[6] Examples are the increased use of private sector providers (for example independent sector treatment centres) and the establishment of foundation trusts. Despite the differences in rhetoric, and despite the belief that Scotland and Wales have set their faces against market-based approaches to healthcare, in legislative terms the ability for them to follow the English line still exists. This point is discussed further in the Conclusion.

Smith and Babbington see the three devolved administrations bring positioned well to the left of England on the left–right axis and having shifted significantly towards the 'nationalist' end of the other axis. As a result, in their opinion, not only has England moved furthest, but it is moving in broadly the opposite direction to Scotland and Wales, and probably Northern Ireland. This analysis was performed before the resumption of devolution in Northern Ireland, when the Province's policy was developed by English ministers and thus perhaps was more strongly influenced by English approaches. If differences between England and Northern Ireland are at present not so marked as those between England and the other two devolved administrations, this may be due to this period during which health services have been run by direct rule from Westminster.

So far, developments in England have continued to confound one of the predictions about innovation made in the first devolution and health report. This was the suggestion 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 organisational experimentation/innovation in the devolved administrations. In fact, where the organisation of health services is concerned, the rate of change and innovation appears to have been greater at the centre (in England) than at the periphery. A similar conclusion, that divergence has occurred through policy innovation within England, rather than in the devolved territories, has

been reached by Raffe, describing developments in comprehensive education. He argues that, while there are divergent attitudes to comprehensive education in the UK, this reflects a refusal by Scotland and Wales to follow the English policy direction, rather than from positive changes on their part. Far from being 'laboratories of democracy', he asserts that the devolved administrations have viewed much of the policy experimentation in England with antipathy.[7]

Whether or not there is innovation, and from whom it comes, the difficulty still remains of determining the performance of the different approaches. There is still little of the comparative evidence that is needed to assess which of the organisational and governance approaches is 'better' at improving health. This point is returned to in the Conclusion.

6.4 The difference between 'the English NHS' and 'UK health policy'

Earlier reports had commented that it was sometimes difficult to determine, both in ministerial speeches and in Department of Health publications, whether the issues being discussed related to England or the UK. In this respect, there has been a sharpening of the Department of Health's focus on England. The Department of Health's latest business plan and its website now prominently promote its overall aim "to improve the health and well-being of the people of England". Specific objectives support this aim. The business plan notes the Department has three distinct but inter-related roles:

- the Department is the effective national HQ of the NHS
- the Department is the major Department of State for a broad and complex range of governmental activity
- in the Department's wider role it is responsible for setting policy on public health, adult social care and a swathe of related topics extending from genetics to international work.

There is, of course, a UK dimension to the second and third of these roles. But the public face of the Department of Health now appears more clearly identified with the English NHS than was previously the case. The framework for cooperation between the Department of Health and the departments or directorates concerned with health and social care in the devolved administrations continues to be provided by concordats, one covering cooperation between the Department and the Scottish Executive and the other covering cooperation between the Department and the Cabinet of the National Assembly for Wales and Department of Health, Social Services and Public Safety Northern Ireland.

There is an inevitable interplay between developments in England and those in the other administrations. It is not only England's size relative to the other administrations that gives it the potential to influence developments in them. Some government departments have to operate at different times in both English and UK roles. Confusion has sometimes existed about whether a particular policy or initiative is a UK or an English one, a confusion which on occasion some UK ministers have seemed keen to encourage. As the earlier

Devolution and Health reports have discussed, the salience of English problems and policies has also been increased by the tendency of much of the UK media to face towards London, and by the relative dominance of UK rather than national media. Smith comments that there are unresolved tensions in the UK government operating on an English-only basis, when there is a requirement to perform UK-wide functions and maintain quasi-federal responsibility.

6.5 Regulation and the role of the professions

Given the divergence between the different health systems, as Smith comments, the lack of a UK focus in health policy means that doctors in the UK face different incentive structures and working environments. For the most part, matters of professional regulation, negotiations on contractual matters, and education and training were reserved to the UK when political devolution was introduced. (In a few cases, regulatory bodies have remits covering Great Britain rather than the UK.) The original 1998 Devolution and Health report[8] suggested that 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 earlier reports described the responses that professional bodies had made to the introduction of political devolution. Some had 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, while others did not envisage making any changes.

The issues to which professional bodies may need to respond can come from a variety of different directions. Over the period covered here, many of the changes have been driven by what the devolved administrations see as a largely English agenda. The English White Paper of April 2002, *Delivering the NHS Plan – Next Steps on Investment; Next Steps on Reform*, in setting out the future plans for the English NHS indicated the need for "fundamental changes in job design and work organisation". These would require new contracts for GPs, consultants, nurses and other staff. The negotiations required to achieve these new contracts were carried out at UK level. As the previous sections related, there has been concern that, although having a voice in the negotiations, in some cases the devolved administrations consider they have ended up with contracts that did not offer enough flexibility to achieve outcomes that matched their particular situations and requirements. This is leading some to question whether, in the medium term, some or all of the devolved administrations may wish to depart from UK-wide arrangements.

Other major issues for the professions over the period of this review were prompted by the need to respond to a number of major failures of management or governance. These included the report into paediatric cardiology at Bristol Royal Infirmary, the inquiry into organ retention at the Alder Hey hospital in Liverpool and the report into the activities for Dr Harold Shipman. These led to the proposals tabled in the White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, published in February 2007[9]. As the discussion in the previous sections indicated, there had been concern

among the devolved administrations about a lack of involvement with the preparation of *Good Doctors, Safer Patients*,[10] the report on which the White Paper was based. There was criticism of the way it had referred to aspects of the English NHS which did not have exact equivalents in the devolved administrations. However, it was noted that the resulting White Paper did more properly reflect the freedoms of the devolved administrations to adopt their own approaches where appropriate. There was much less concern about the processes used in the preparation of the report *The Regulation of the Non-medical Healthcare Professions*.[11]

6.6 The governance challenges for professional bodies

Devolution has faced the professional bodies with a dilemma. By their very nature, they are well-placed to 'hold the ring' and keep all-UK networks operating as divergence increases among the policies and practices of the different administrations. But their members judge them to a large extent by how well their interests are represented in the arenas that have the most impact on their work. For those working in the devolved administrations this means they now expect their professional bodies to have a high profile with the respective health departments.

As Jervis and Plowden's 2003 report described,[12] this requirement has posed challenges for all professional bodies. In nearly every case, it has resulted in 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. A particular challenge is that of policy formulation. Although the UK's professional bodies have adopted a variety of different organisational forms, one common theme relates to the difference between policy formulation and implementation. Typically, policy formulation has been the responsibility of the most senior representative body, often the 'Council'. Starting in the days of administrative devolution, a number of professional bodies have had country-based structures – Irish, Scottish and Welsh 'committees' or 'executives' for example – which have been granted delegated responsibilities for implementation of those policies, with a greater or lesser degree of licence to tailor implementation to country-specific requirements.

What has become clear more recently is that political devolution challenges the policy /implementation split. While it worked well when all policy initiatives started from the centre, it is less appropriate when they can arise in any one of four centres. If there was confidence that differences were only ones of timing then they could be more easily accommodated – as when Scotland pioneered the smoking ban, but within a relatively short time the other administrations had caught up. But there is no guarantee this will always happen. The Welsh abolition of prescription charges, for example, may or may not be followed by other administrations.

There are important 'operational' considerations here. When there is diversity, it may be harder for policy to be developed 'in the centre'. Should a professional body's response to a policy initiative in a devolved administration be developed by its representatives in that

administration, and if so, what is the status of that policy response for its members in other administrations? If responsibility for policy development is devolved, it raises challenges in terms of capacity and expertise, as well as challenging existing governance models. Diversity also tests the 'intelligence system' of any organisation. It becomes harder to be forewarned and prepared if issues can arise in four locations than when a single source had to be monitored.

Professional bodies, therefore, are being pulled in two directions. There is a growing need, particularly prompted by European and other international developments, to be able strongly to represent the views of their profession at the UK level. At the same time, there is a need to represent the views of the profession to four different administrations, sometimes following different policies. It raises the question of whether a particular professional body always needs to lobby for conformity across the UK, or whether divergence be accepted in at least some instances. And what are the implications for its membership in any administrations that are out of step with others? Both the governance challenges and the resource implications are likely to increase if the different health systems continue to diverge.

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7. THE IMPACT OF POLICIES FOR PUBLIC SERVICE REFORM

7.1 Introduction

Health policy is a topic of study in its own right, as is the organisation and management of health services. But, as currently organised and delivered in all UK countries, the vast majority of health services are part of the wider array of public service provision. Public service reform has been a priority for all the UK administrations, and the period covered by this report has seen a number of major reports and policy initiatives. These are reviewed briefly below, and some of the similarities and differences discussed.

Public service reform, and the need for it, formed a continuing mantra for the Blair government in the UK. However, since responsibility for the funding, organisation and governance of public services in the devolved administrations lies in Belfast, Cardiff and Edinburgh respectively, reform of public services thus involves one of the classic challenges for political devolution. Reform can be a central focus of the reforming drive of the UK government, but its implementation is not fully within its control.

7.2 The UK Government (with direct responsibility for English services)

The scope for tension between Whitehall and the devolved administrations is demonstrated by the 'policy reviews' carried out in early 2007 by the then Prime Minister's Policy Unit and endorsed by the UK cabinet. Popularly described by political commentators as an attempt by the outgoing prime minister to secure his 'legacy', and to ensure that the incoming administration would continue the main policy trajectories, these reviews were described as "a fundamental, wide-ranging look at what can be achieved over the next 10 years". The reviews encompassed a variety of methodologies, including some that were characterized as "new and often innovative forums for generating new ideas". Citizens were directly involved in the process through 'deliberative forums' held in different parts of the country and a 'Citizen Summit' held at Downing Street. Ministers from across the Government also participated in seminars on a range of subjects.

The first of the policy reviews to be published, in March 2007, was entitled B*uilding on Progress: public services*.[1] The report is clearly labelled as an 'HM Government Policy Review'. Yet when citing the sorts of innovation that can be used to improve public service delivery, the majority of examples are English. The policy review is clear about its central vision:

> *The vision at the heart of this paper is to create self-improving institutions of public service, independent of centralised state control, drawing on the best of public, private and third sector provision.* (p. 7)

It is equally clear about the central means of achieving this, 'personalisation', making services more personally appropriate to citizens:

> *The purpose of public service reform is to enhance opportunity and improve the quality of life for citizens, by making services more personally appropriate to them.* (p. 9)

The review does not argue for a 'one size fits all' approach to reform, commenting that it draws on a body of evidence about what kind of organisational model tends to work best in which services, and at what stage of development. But it also states clearly that:

> *the public are quite clear that the existence of alternative providers does not compromise fairness, as long as services remain free at the point of use.* (p. 11)

Personalisation and choice are major themes of the review. It notes that choice-based reforms are now well advanced across UK public services. But one area in which more might be done is acute healthcare, where there is a case for extending patient choice from four hospitals (the current English approach) to all qualified healthcare providers – public, private and voluntary. The review's argument is that, increasingly, public services need to be designed around the user, and that therefore these will depend on personalisation. But:

> *There is no point in empowering citizens if their expressed preferences cannot be met – and because different people want different things, a broad base of suppliers is needed.* (p. 44)

The review states that the Government has begun to increase the diversity of public service providers, ensuring that the best providers (whether from the public, private or third sectors) are selected. This increased diversity of providers "has helped to encourage innovative practice that can meet a broader range of user needs" (p. 44). Examples of this approach cited include Academies and Specialist Schools, which have enhanced the diversity of the schools system, with "results in Academies improving faster than the national average"; independent sector treatment centres in healthcare, which are "helping to reduce waiting times for patients", and the way in which the private sector is continuing to play a crucial role in the management of prisons.

The review outlines various actions by which the Government can facilitate a more open and diverse supply side. These include setting policy frameworks with clear objectives, establishing effective regulation, and developing mechanisms for dealing with under-performance. Government should also ensure that no one provider is given a privileged position, thereby enabling the full contribution of all potential providers to be harnessed. The review also proposes that, where service outcomes can be specified in a contract, the Government increasingly should seek to separate the role of commissioner of

public services from that of provider. The review argues strongly that commissioner/provider separation helps to avoid conflicts of interest, allows commissioners to focus on getting the best service at the best price for the user, and helps to encourage competition between providers (whether public, private or third sector). It adds that a more explicit separation of commissioner and provider does not mean that in-house provision is not possible, but does mean that it should be provided through an arm's length operation.

The review notes that separation of purchasers from providers offers the potential of a greater diversity of public service provision, providing that providers can compete on a fair basis. This is particularly true of the voluntary sector. This sector faces a number of barriers to entry where public sector provision is concerned, yet it has the potential to bring more diversity to the supplier base and help to catalyse public service reform through innovation and by informing the design of services. Making greater use of the third sector and introducing purchaser–provider splits also enables greater use of contestability to drive service improvements. Noting that contestability is used in some service areas to a much greater extent than others, the paper argues for a service-by-service assessment of where contestability might be extended. The specific examples given include the provision of GP services and diagnostic services.

The review also argues for extending contestability to commissioning bodies as well as those providing services. While this would not be desirable across the board, it might be appropriate where a step-change in the quality of commissioning is needed. The commissioning of local healthcare is given as one particular example, where "the primary care trust could contract external commissioners while maintaining the important link with the local population it serves". It is also suggested that potential providers should be allowed to bid to take over a service if they believe that they could provide something better at a more reasonable cost. If this review sets out the agreed vision and direction of the UK government, the extent to which it is implemented in the devolved administrations depends on the approaches they adopt. As the following sections show, there were important differences of emphasis, even prior to the 2007 elections.

7.3 Northern Ireland

As with all other parts of this analysis, the situation in Northern Ireland has been different, with the direct rule from Westminster continuing almost to the end of the research. But the focus on public services has, if anything, been greater. Its major manifestation has been the Review of Public Administration, which was launched by the Northern Ireland Executive in June 2002, while the Stormont Assembly was still operating. On the suspension of devolution in the autumn of 2002, the review was progressed by direct rule ministers, taking account of the views of the local political parties and others. The review was described as:

> *A real opportunity to revitalise public services in Northern Ireland, to replace current structures with a new, more accountable public sector, working together with a common purpose to meet the needs of the 'on-demand' lifestyles that people now lead and have rightly come to expect from our public services. It is an opportunity to realise the vision of a world-class Northern Ireland.*[2]

It involved a comprehensive examination of the arrangements for the administration and delivery of public services in Northern Ireland. It covered over 150 bodies, including 26 district councils, the Health and Social Services boards and trusts, the Education and Library Boards and about 100 other public bodies.

The outcomes of the review were announced in two parts: in November 2005 the Secretary of State announced final decisions on the future of local government, Education and Health and Social Service structures; and in March 2006 he announced decisions on the remaining public bodies.[3] Inevitably it was the proposed organisational restructuring which attracted much of the attention and comment.

In the spring of 2007 the plans were that, in local government, councils would be reduced from 26 to seven by 2009, with an independent Boundary Commissioner deciding the exact boundaries of the new councils based on groupings of existing councils. The new councils would have an increased range of powers including: local roads, planning, rural development, planning local bus services, fire and rescue, future European programmes and some housing related functions. The councils would also have a statutory duty to lead a community planning process, and there would be a statutory duty on all other agencies to work with the councils. A system of statutory checks and balances was to be developed to ensure there was fair and transparent decision-making within the new councils and a new system of local government finance would be developed. There was similarly a major restructuring of the education system, with the establishment of a new Education and Skills Authority to focus on the operational delivery of educational services, the strategic planning of the schools' estate and ensuring the delivery of the 14 to 19 curriculum.

A major restructuring of the health and social services system involved the creation of a considerably smaller and strategically focused Government Department and the establishment of a single Health and Social Services Authority to replace the existing four Health and Social Services Boards. This was to drive performance management of the sector. It was to contain a number of Local Commissioning Groups which would map onto the new district councils and would be "demand led by patients and driven by GPs and primary care professionals". One Patient and Client Council was to replace the existing four Health and Social Services Councils, and 18 Health and Social Services Trusts were to be reduced to five, with the Ambulance Service remaining as a separate trust. Under the direct rule process, ministers proceeded with the implementation of the review's recommendations. In particular, in health appointments were made to the new HSSA, to operate in shadow form until April 2008, and the new HSS trusts went live on 1 April 2007.[i]

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i The review also involved major changes to quangos, with 81 public bodies being reduced to 54 through a combination of merging bodies or transferring complete functions to local government or central government. All of the bodies that remained would be required to work with councils in the community planning process. All appointment to public bodies would be made on merit, with board members being appointed under the guidelines laid down by the Commissioner for Public Appointments.

Implementation of the plans in health was well advanced in spring 2007, but some who were interviewed questioned whether a 'local' health minister would be happy with the new HSSA interposed between him/her and the service itself. It was reported that there remained controversy about some of the recommendations about local government restructuring. With the resumption of devolved government it remained to be seen if the new Assembly would seek to alter any of the review's decisions. The Northern Ireland initiative focused somewhat more on structural reform than its equivalent in other administrations, with issues of governance, accountability and transparency very much to the fore. This was to be expected given the Province's history, and as a result the theme of personalisation received somewhat less attention, as did requirements to diversify the supply side of public service provision. However, there was still much in common with public service reform thinking in the other UK countries.

7.4 Scotland

Scotland too has addressed public service reform. The Scottish Executive published *Transforming Public Services: the next phase of reform* in June 2006.[4] In the Ministerial Foreword, Tom McCabe, the then Minister for Finance and Public Service Reform, wrote:

> *Our public services form an integral part of modern Scotland. … we must be prepared to transform the way that they are organised. Public service reform will enable us to meet the changing needs of modern society and to deliver the outcomes that create a fairer and more equitable society.* (p. 1)

He stated that progress on reform was an opportunity upon which Scotland could build by taking the chance to look at public services in their entirety, considering long-term options and delivering an improved framework for the people of Scotland:

> *The overriding aim of this complex and substantial work is not just to help us sustain the volume and quality of our public services; it is to radically improve on both and to recognise the need to rationalise our organizational structures wherever necessary.* (p. 2)

Scotland's reform process started from a strong belief in the value and importance of public services. The Executive had invested heavily in public services since 1999, and that investment, combined with measures put in place to improve performance and efficiency, had delivered real benefits. The case for reform was not based on an assumption that public services were generally failing. But Scotland's public services had to be more responsive and effective. The country faced a number of long-term challenges over the next 20 years, which could not be met unless the pace of modernisation and reform could be accelerated.

The Scottish vision for public services, like the English, was that of a more diverse and individualistic society with different aspirations and expectations. As a result "People ... expect services tailored to their needs". Other drivers of reform were the fact that the unparalleled growth in expenditure on public services in recent years was unlikely to continue indefinitely; the rate of technological change which offered opportunities to

deliver services in new ways, but also risked increased inequality; and the demographic changes the country was facing. Further, recognising the public's declining engagement with the political process there could be a loss of trust in public services unless Scotland could demonstrate that they were valuable and efficient, and matched the best that could be found elsewhere. The Parliament and the Executive had been grafted onto an existing institutional landscape, and it was now time for a new settlement in the public sector, to give a framework which would equip the country to meet the challenges of the next 20 years and beyond, "without making the mistakes of previous costly reorganisations".

The Scottish reform built on a number of fundamentals. First and foremost was that services must be designed around the needs of service users.

> *We are moving towards more flexible, user centred services, but we must go further. In doing so, we need to learn from other sectors, be it voluntary or private, whilst respecting what is valuable about the public service ethos.* (p. 9)

Scotland echoed the English/UK belief in 'personalisation' and user focus. Making user focus the primary goal meant a commitment to greater responsiveness to individual needs, lifestyles and work patterns. It also involved widening the choice people had over the kind of services that were on offer; organising services around the needs of users, not institutional silos; and strengthening the accountability of services to communities. Scotland had always had a mixed economy of public services, with services delivered by public sector bodies, the voluntary sector, private organisations and individuals. Scotland too repeated the English belief that, for most public services, the most important issue for the user was not who ran the service, but whether it could be accessed locally and how locally accountable, efficient services could be secured. Scotland also paralleled England in endorsing the importance of the voluntary sector and of looking for ways of assisting the sector to grow its role.

The caveat was "that user choice cannot be the only solution to improving public services" and the rhetoric perhaps placed a greater responsibility on citizens to help shape services:

> *Our vision is for personalised public services, which not only view service users as consumers, but also as participants and citizens – working with public services to create better lives for themselves and their communities and having responsibility for the choices they make.* (p. 11)

Elements of the necessary approach included fostering a culture of innovation; stressing efficiency and productivity; 'joining up', strengthening democratic accountability and using outcomes-based measures.

The Scottish approach partly reflected the emergence of a more decentralised state and a networked, collaborative approach to service delivery. However, it recognised the downside that enormous amounts of valuable professional resources must be invested in order to make these complex arrangements work together. This "presents us with a real risk that we simply end up managing fragmentation which fails to deliver real benefit for the user and greater efficiencies in how we organise our public services" (p. 32). It argued that many benefits would flow from a more coordinated approach to public service

delivery. The challenge, therefore, was to determine what would be the best structure to plan and deliver public services to a nation of five million people.

> *The status quo should not be seen as an option as we move to more modernised configurations of services.* (p. 32)

The Scottish approach appeared to leave scope for employing the same range of policy levers that the UK government review itemised. The major differences lay in the greater emphasis placed on engagement of the public as citizens in contributing to the design and development of services, not simply as consumers or users employing choice or exit. While still among the policy options, the Scottish approach seemed to place less emphasis on the use of private sector suppliers and the encouragement of new organisations to enter the market as providers.

7.5 Wales

The main vehicle in Wales for examining public services was the Beecham Review, established by the Welsh Assembly Government in July 2005 as part of the action plan for implementing its Making the Connections strategy for improving public service delivery.[5] In the introduction to the report, published in June 2006, the Chairman Sir Jeremy Beecham stated that:

> *The context for our review is the rapidly maturing process of devolution, which has transformed the governance of Wales. Very rapid progress has been made to create a new machinery of government and we commend the dedication and skill with which this scale of organisational change has been, and is being, managed.* (p. 1)

He argued that this change in governance had had a huge impact on local service providers seeking to respond to the aspirations of the Assembly Government, not only to improve services, but also to tackle Wales' long-standing economic, social and health problems.

The review concentrated on cross-cutting themes which influenced the performance of services across sectors, including organisational structures; governance and accountability; performance management; strategy and planning; business processes and finance. One of the review's outcomes was the further articulation of the 'citizen model' which had been advocated in *Making the Connections* as the driver for public service reform in Wales. The review described this as a complex and challenging model, with major implications for all public service organisations. It noted that, in England, the Government was seeking to respond to the new public service challenges through a customer model which emphasised choice as the means to meet consumer expectations, with competition, contestability and elements of market testing as the way to achieve efficiency.

It commented that:

> *This model assumes that well-informed customers, who are empowered to express their needs and preferences, will drive service change through the impact of their choices. This has not*

> *found favour in Wales, on grounds of both principle and practicality, including the demography in rural and valleys areas where the sustainability of alternative suppliers is in question.* (p. 5)

In the articulation of the citizen model, the Welsh Assembly Government had begun the process of developing an alternative that fitted with the historical, cultural and geographical context in Wales. In the consumer model, the key driver for service improvement was *exit*. Customers expressed dissatisfaction with services by choosing a different provider. But in the citizen model, exit was not the driver of improvement. Instead, the model relied on *voice* to drive improvement, together with system design, effective management and regulation, all operating in the interests of the citizen. Understanding of this point was fundamental to the design of the whole system of public service delivery for Wales. All parts of the system had to be congruent with the citizen model.

> *Importing levers from different models will not fit, and will simply create unnecessary complexity and perverse outcomes. The challenge for Wales is to demonstrate that the citizen model can deliver on its own merits.* (p.5)

Because of this, the review's message was that change needed to be taken much further and more rapidly, based on a shared understanding of the citizen model and its implications. This shared understanding would be the glue which would hold together the different spheres of government and public service bodies. "It is a constant reminder of why public services exist and that the citizen comes first" (p. 7).The important strengths of present arrangements included:

- a common purpose based on the tradition of mutuality and support for the Making the Connections citizen model
- scale, in that local organisations were close to communities and the national government engaged directly with partners in policy development
- partnerships, both national and local, including the statutory partnerships with local government, the voluntary sector and the business sector which provide the basis for good communication and engagement with the Assembly Government
- workforce engagement with a commitment to strong communication and engagement with staff representatives.

The review also noted that co-terminosity at local level of the key delivery organisations had been a positive factor. The result had been service performance in some categories which outperformed the same services in other parts of the UK. Nevertheless, problems remained, and the report focused on what needed fixing. The citizen model required public organisations to find much more effective ways of engaging the public in the trade-offs across the whole system of public services than had been the case previously. The particular circumstances of Wales made this easier to achieve, because of the very practical sense in which the governance process has come together since devolution. The Assembly Government was in the middle of a change programme based on the Making the Connections strategy. This envisaged a new Welsh public service based on flexible

networks of diverse pathways involving a range of organisations, all working to a common citizen-centred model of delivery.

The report articulated a clear vision of 'small country governance' and challenged the country to grasp it.

> *We believe that Wales needs to embrace a much more ambitious vision of the future of public service delivery and governance, which builds on the huge potential advantages available to a small country. Wales should learn from other small countries and become a benchmark for delivering flexible, citizen-centred local services.* (p. 55)

But to reap these benefits, the key driver of change had to be local pride, ambition and accountability – with all public service bodies using their joint resources to secure better outcomes for citizens in their area. The role of the Assembly Government should be to design and lead a delivery system which enabled and supported this vision. This meant moving from the traditional, detached central government role of issuing strategies, regulations and targets to far more engaged leadership of the delivery process.

The scale of Wales made this possible, through direct communication between the Assembly Government and local organisations, supported by more streamlined procedures, more joint delivery of public services, more flexibility of organisational structures, and more effective engagement with the citizen. But importantly structural reorganisation was not the answer, nor was a 'one size fits all' approach appropriate: "change must be driven by local leadership, supported, but not imposed, by the Assembly Government" (p. 56). The report made some specific comments about health:

> *The case for a closer association between local government and health is particularly strong. Expectations of joint commissioning, provision and scrutiny should be ambitious. More ambitious models should be encouraged, as a minimum there should be joint health and social care scrutiny.* (p. 56)

The Beecham review identified the ingredients necessary to deliver the citizen model, and like Scotland, also echoed the English theme of using a mixed economy of provision, which is "necessary in order to achieve a step-change in performance". The search for citizen-centred solutions had to include genuine and open partnership with the private and third sectors, as a means of enhancing innovation, expertise and delivery capacity. It also stressed the need for investment in developing the capacity of the third sector to support this. It went on to recommend that:

> *This mixed economy should be based on a level playing field, where local authorities can, and should, provide services where they are best placed to do so, or where public service provision needs to tackle a private monopoly or gap in service. Local authorities should take advantage of their new trading powers to sell their services, on a competitive basis, to other public organisations and the wider market.* (p. 62)

7.6 Approaches to public services compared

Citizen-centredness, therefore, is a theme which unites the aspirations of the UK government and those of the devolved administrations. A useful comparison between English and Welsh approaches to the development of citizen-centred public services has been made by Brand.[6] He comments that there were initial fears that devolution would reverse the progress made on the localism agenda, leading to a recentralisation of powers with the new assemblies. He argues that this has not proved to be the case, stating that councils in Wales and Scotland have "built on their advocacy of devolution before 1997 to realise a closer partnership with devolved government". As a result, advocates believed a shared vision between central and local government had emerged, supported by new, more relevant policies for devolved areas.

How much had really changed, and how far apart were the new devolved visions? Brand suggests that an analysis of *Strong and Prosperous Communities* and the Welsh Assembly's *Beyond Boundaries* can help answer these questions. These papers provide an indication of how local government policies may be diverging or converging across devolved nations. Although both papers seek to improve the way services are delivered at a local level, each makes different assumptions and sets out a different path. Brand suggests that devolution has not taken local government to divergent extremes, but it has led to differences in vision and approach that both contain important lessons. These include:

- the requirement for local government to engage with citizens in the design, delivery and decision-making process, to ensure that services meet the needs of those who use them
- the need to join-up and share across organisational boundaries, to ensure the delivery of effective and efficient services.

While these two themes are essential to both English and Welsh strategies, there are revealing differences in tone, style and approach.

The Welsh vision, he argues, relies on a sense of responsibility and community. It emphasises the role of all stakeholders in making the model work and promotes the importance of working together to deliver it. This suggests a sense of partnership and mutual understanding, core values which would "underpin a set of new, more democratic, inclusive and relevant services that encouraged people to participate in and contribute to their design". However, this is an ambitious vision and it is not clear how Wales intends to achieve it. There is not a clear 'route-map' for local authorities to follow. As one example, Brand comments that the Welsh system is expected to take on board and support the wishes and opinions of all citizens, even those not engaged with a given service itself. "This may be too much to ask of those detached from political processes and with no vested interest in the delivery of the service involved."

Table 7.1 Policy approaches in Wales and England

Wales	England
Community based	A spirit of competition
Citizen involved at all stages	Citizens primarily involved in approving and mandating services
Full system approach	Targeted, specific and pragmatic goals
Ideological and 'big picture'	Pragmatic and tangible
Citizen is at the centre of the design process	Citizen is at the centre of local government's thinking
Citizen involvement is core driver for change	Competition, efficiency and satisfaction are core drivers for change
Power is shared between all stakeholders	Service users have the power to 'opt-out' and show dissatisfaction through exit

Source: Brand, Devolution and Divergence

By comparison, the English White Paper may not be as ambitious in its use of citizen engagement for driving change. There are reasons for that. One is simply scale. "If a 'coproduction' approach was adopted in England, how would local government go about involving 60 million people in the design and delivery of services across the country?" The large and heterogeneous nature of local government in England does not lend itself so easily to the inclusion and integration of all citizen voices. The English paper does make clear recommendations for achieving its own citizen-centred goals. These include:

- statutory guidance on the new best value regime
- identification of best practice in extending choice and involving citizens throughout the commissioning cycle (including launching a new Beacon scheme entitled Empowering Citizens: Transforming Services)
- providing contractual incentives to meet user expectations
- working with local authorities to test methods for empowering people to help design services
- ensuring audit assessment gives weight to the use of citizen intelligence.

Such levers and legislative tools are necessary if English authorities are to drive change. Given the size of the structures and systems involved, Brand questions whether engagement alone would provide a sufficient engine for improvement, particularly within a monopoly public service provider. Therefore *Strong and Prosperous Communities* relies on the more obvious tools of public dissatisfaction (or discontent) and, where possible, exit to drive change. This puts the power solely and firmly in the hands of the user or consumer. Brand argues that when the final power to approve or mandate services lies with citizens, or where a viable choice exists, the motivation for services to adapt, change and respond is stronger.

7.7 Conclusion

In the 'shorthand' used to describe differences between the various administrations' attitudes to public services, it is frequently asserted that England is in favour of the 'marketisation' of public services while Scotland and Wales have set their faces against this. Analyses such as those by Smith and Babbington[7] show that more than a single dimension, state provision versus a mixed market, is needed to describe fully the differences that are developing. But simply in terms of the use of a mixed supply side, while much of the rhetoric in the devolved administrations has been opposed to the use of the private sector to provide public services, the fine print of the various policy documents reveals a somewhat different picture. The existing legislation appears to enable the use of all options for providing public services in all administrations, even though currently the mix of mechanisms being used, and the emphasis on them, differs.

In Wales, the report *Making the Connections* seeks to reform public services in Wales based on the citizen model as the central, unifying idea to lead change across delivery organisations. Following the May 2007 elections the Welsh Labour party and Plaid Cymru negotiated the formation of a coalition government. The agreement included an endorsement of the principles in the Beecham report, and also a statement explicitly rejecting the use of privatisation of markets in healthcare:

> *We firmly reject the privatisation of NHS services or the organisation of such services on market models. We will guarantee public ownership, public funding and public control of this vital public service.*[8]

In the development of policies for public services, the Welsh 'citizen model' is particularly interesting, as is the analysis of its strengths and weaknesses by Brand cited above. The emphasis Scotland places on the service user as participant and citizen as well as consumer appears to have much in common with the Welsh thinking. If England is different, is it mainly, as Brand suggests, because of the scale differences which mean the 'co-production' model of public service policy is not feasible, or are there deeper ideological differences?

There appear to be both compelling pressures encouraging marketisation and also resisting it. Forces tending to favour marketisation of health services include the growing influence in health of the European Union, and specifically of its Single Market legislation and its interpretation by the European Court of Justice (ECJ). Despite the many previous assurances that decisions about the mechanisms used to finance and deliver healthcare must be taken in the national context, including decisions about the extent to which it is appropriate to rely on market mechanisms and competitive pressures to manage health systems, the European Union's proposed health strategy is not likely to overturn the ECJ judgments which have already had significant impacts on heath services. EU developments in health are discussed in more detail in the next chapter.

On the other hand, the fact that Scotland now has a nationalist administration, and the Welsh nationalists have entered into coalition with Welsh Labour in the Welsh Assembly

Government may reduce the enthusiasm in those administrations for market-based approaches. Will these changes of government in Scotland and Wales lead to any differences with England being embodied more firmly in policy? Even in England it was being suggested by health experts in the run-up to the Brown premiership that the pendulum might swing away from markets, with less emphasis on the use of the private sector and a slow-down in market-based reforms.[9] Whether the future will bring more marketisation, even in those administrations currently resisting it, and what the impacts will be on equity, efficiency and effectiveness, are two of the most significant unresolved questions.

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8. THE IMPACT OF EUROPEAN DEVELOPMENTS ON UK HEALTH POLICY

8.1 Introduction

Jervis and Plowden's 2003 report, cited in previous chapters, noted that the influence of the European Union in health policy had increased rapidly in the previous three years, and forecast that the process was likely to accelerate. It suggested that this might pose challenges for the UK policy machinery, and for intergovernmental relations. The formal position now, as it was in 2003, is that, within the European Union, most competence for action in the field of health is held by Member States. However, the EU has the responsibility, set out in the Treaty, to undertake certain actions which complement the work done by Member States, for example in relation to cross-border health threats, patient mobility and reducing health inequalities. Further, in the four years since the last report was written, the development of the EU's role has indeed increased significantly, and it continues to do so. Importantly, a significant part of the impetus for this has come not from the EU's competence in public health, but from developments in other areas of its competence, such as the further development of the Single Market. The various initiatives of the past four years, some of which are still ongoing, now form an important and developing context within which national and, in the UK, devolved administration health policy must be formulated.

8.2 European health strategy

At the time of writing, a new health strategy for the European Union has been published,[1] the result of a process which has been underway for several years. In May 2000, a Communication on health strategy at EU level was adopted. This called for concentrating resources where the Community could provide real added value, without duplicating work which could be better done by the Member States or international organisations. Supported by the public health programme, it led to the development of public health activities and to strengthening links to other health-related policies.

In 2002, general health policy lines were set out in the concept of a Europe of Health. Work was undertaken on addressing health threats, including the creation of a European Centre for Disease Protection and Control, developing cross-border cooperation between

health systems, and tackling health determinants. In 2004, to review and if necessary revise the 2000 health strategy, the Commission launched a reflection process on Enabling Good Health For All. This asked what should be done at EU level in the field of health. The messages the Commission received from a broad range of stakeholders was that a European Community strategy should include a focus on:

- mainstreaming health into all Community policies
- health inequalities across the EU
- health promotion and disease prevention
- key issues such as mental health and cross-border matters
- global health.

The European Commission's new health strategy aims to provide, for the first time, an overarching strategic framework spanning core issues in health as well as health in all policies and global health issues. The strategy aims to set clear objectives to guide future work on health at the European level, and to put in place implementation mechanisms to achieve those objectives, working in partnership with Member States. An important building block of the new strategy will be the European Union's statement of common values and principles underpinning health systems.[2] One trigger for developing this had been the debate about whether health services should be included in the Single Market's services directive.

8.3 The Single Market and health services

Jervis and Plowden's 2003 report mentioned the early rulings of the European Court of Justice on the rights of patients to benefit from medical treatment in another Member State. In the intervening period there have been a number of further decisions of the Court which have impacted on health services. Following these judgments, in 2003 health ministers and other stakeholders invited the Commission to explore how legal certainty could be improved.

At the beginning of 2004, the Commission's proposal for a directive on services in the internal market therefore included provisions codifying the rulings of the Court of Justice in applying free movement principles to health services. However, this approach was not accepted by the European Parliament or Council, and health services were removed from the directive before it became law. Given this, the Commission therefore undertook to explore how best to develop a separate specific initiative on health services. This process culminated in a formal consultation, Community Action in Health Services, launched by the Commission in September 2006, with a view to bringing forward specific proposals in 2007. This is discussed in more detail below.

8.4 Common values and principles

At the Employment, Social Policy, Health and Consumer Affairs Council meeting in June 2006, the (then) 25 Health health ministers of the European Union issued a statement about the common values and principles that underpinned Europe's health systems.[3] They

did so believing such a statement was important in providing clarity for European citizens, and also timely, because of the recent vote in the Parliament which had led to the removal of healthcare from the proposed directive on services in the Internal Market. The health ministers expressed the strong belief that developments in healthcare should result from political consensus, and not solely from case law, believing that it was important to safeguard the common values and principles as regards the application of competition rules on the systems that implement them.

The four overarching values identified were universality, access to high quality care, equity and solidarity. Together they constituted a set of values that, it was claimed, were shared across Europe. At a more practical level, six operative principles were identified:

- quality
- safety
- care that is based on evidence and ethics
- patient involvement
- redress
- privacy and confidentiality.

The ministers argued that the values and principles should guide policy decisions, both in respect of healthcare systems within Member States and in their interactions across Europe. They claimed that the values were the basis of Europe's socially-orientated healthcare policies and shaped and reinforced the European Social Model.

The Commission publication announcing the statement of values and principles confirmed that decisions about the basket of healthcare to which citizens were entitled and the mechanisms used to finance and deliver that healthcare must be taken in the national context. It confirmed that it was not appropriate to try to organise health systems at an EU level, but argued that there was immense value in work at a European level on healthcare.

The ministers' statement also acknowledged that the practical ways in which these values and principles became a reality in the health systems of the EU varied significantly between Member States, and would continue to do so. This included decisions about the extent to which it was appropriate to rely on market mechanisms and competitive pressures to manage health systems, and the different provisions implemented to ensure equity, with some Member States electing to express these in terms of the rights of patients and others in terms of the obligations of healthcare providers.

From more recent developments, it is clear that the European Commission now sees this statement of common values and principles as a very significant advance in the development of European policy, and something on which all new policy initiatives will build.

8.5 The EU consultation on cross-border healthcare

This consultation launched in September 2006 focused on cross-border healthcare, of which four types were identified: cross-border provision of services; use of services abroad

(usually referred to as 'patient mobility'); permanent presence of a service provider in another Member State; and temporary presence of persons in order to provide services (usually referred to as 'professional mobility'). The Commission stated that its objectives in any initiative would be to provide clarity and certainty regarding the application of Treaty provisions on free movement to health services following the Court of Justice rulings, including the necessary clarity on medical, regulatory and administrative issues. The consultation closed in January 2007, and the Commission's further proposals were due to be published in November 2007.

For the UK, in the context of devolution in health, there is no specific *internal* issue raised by these developments. There is only a single Member State of the European Union, the United Kingdom, and any of the categories of mobility within the UK would not be classified as cross-border healthcare, and thus would not be affected by any legislation. However, citizens in all four UK countries would be affected by any new legislation, as they are already by the existing judgments of the ECJ. In addition, any developments might be of specific relevance to Northern Ireland, which is the only country within the UK which has a land border with another Member State. The main domestic issue raised by the consultation was how to formulate a UK response with which all administrations could feel content. The response which was submitted by the UK, prepared by the Department of Health in its all-UK role, took account of the views of stakeholders who contributed to a consultation in the UK, and views expressed in the UK Parliament, following the appearance of the Minister of State for Health Services before both a House of Commons Standing Committee, and a Sub-committee of the House of Lords European Union Select Committee.

The UK view stressed that Member States should continue to be able to discharge their responsibilities for the management and operation of the health systems of the European Union, and that further work was needed on how the impact of the Treaty might be managed to ensure this. It noted that currently the scale of cross-border patient mobility in the UK was low with, in 2005/06, only around 280 people going abroad specifically for treatment. The UK response identified a number of specific conditions that should be fulfilled by any legislation, including:

- The home health system in the individual Member State needed to be able to determine what healthcare services were offered to individual patients, and to manage the clinical decision about whether, given the individual circumstances of the patient, 'undue delay' applied.
- Patient mobility needed to be 'cost-neutral' to the home health system: where patients chose to go abroad this should not cost their home health system more than it would have done to treat them at home.
- There should be clarification that, when patients request to go abroad in order to be treated (as opposed to services directly commissioned abroad), it is the standards of care, governance and redress arrangements of the *Member State of treatment* that should apply: health systems could not take responsibility for the actions of providers they did not regulate or assess.

- The principles of equity and solidarity needed to be respected with regard to patient mobility, thereby avoiding the risk of creating a system whereby those EU citizens who could afford to pay for services up front could access healthcare services faster than those with greater needs.

In the case of this EU policy initiative, evidence from the interviews conducted in the different countries indicates that the processes for formulating the UK response seem to have operated well, with the devolved administrations feeling that they had sufficient opportunity to contribute to the formulation of the response, and being content with its content.

8.6 Future developments

Indicators of likely future European developments came from two different sources. The first of these was the presentation made by Robert Madelin, the Commission's Director General for Health and Consumer Protection, at a European Health Management Association Conference in March 2007.[4] In this he stressed that any EU action on health services did not mean or imply harmonising national health systems, and confirmed that the benefits provided by national health systems and their organisation should and would remain the responsibility of the Member States. Madelin reported that the information collected by the Commission indicated that market imperfections existed associated with cross-border healthcare. He cited a recent survey in one Member State which found that while 25% of the population were in principle interested in healthcare abroad (provided that it would be reimbursed at normal rates), only 2% had in fact used such healthcare. The consultation had confirmed that there was a lack of comprehensive reliable data on cross-border healthcare, and in addition the evidence seemed to suggest that the current impact was somewhat bigger than the Commission had estimated in its consultation paper. The indications were that the numbers involved were perhaps seven to ten times as large as the Commission's first estimate, which had been at the 1% level.

Another source of information about future developments is the paper prepared by the 'Trio Presidency' (Germany, Portugal, Slovenia) for the informal meeting of health ministers in Aachen in April 2007.[5] This made it clear that, in the long run, the aim should be to establish "a real health policy for the EU" which should be based on the common values and principles agreed by the Union in June 2006, thus ensuring better health for all citizens through all policies.

It argued that health policy responsibility was both cross-sector and cross-border, and therefore a joint commitment for all Member States. It went on to state that:

> *We continuously strive for a community-wide convergence of standards of living. In terms of health care this means that we aim to enhance the standards of care we provide to our citizens with the goal of attaining the best possible level.*

Despite the aim of convergence, the paper confirmed that: "we are determined to maintain the national competence for health care organisation". Nevertheless, the common

healthcare challenges called for a joint effort to identify viable political solutions. This meant deciding:

- What was the most appropriate level, what were the most appropriate tools to deal with adequate health across Europe and with cross-border issues of provision of health care?
- Which issues were best dealt with: (i) in a regulatory framework, (ii) on a bilateral or multilateral basis between Member States, (iii) and at an operational level?
- How and where could the Commission create clarity and legal certainty where it was deemed necessary?
- How could the Community add value while fully respecting the principle of subsidiarity?

The Trio Presidency paper argued that the European Union needed

> *a Vision, which should set out areas where there is real added value from further co-operation at the EU level, so that the European citizens can win in terms of increased mobility without questioning the sustainability of their own health systems.*

This should be supported by an ambitious strategic framework setting out overarching objectives, priorities and milestones for European health policy. These objectives would set the direction for the coming years, and would aim to tackle some of the challenges facing a changing Europe. Developing this was not just a task for DG SANCO,[i] but needed to involve the many other Commission Services which were working towards the same health goals. A specific need was for a clear roadmap which addressed all aspects of cross-border care. This should be developed working jointly with key stakeholders including other European Commissioners, the EU Parliament, non-governmental organisations (NGOs) and the private sector. The ministers believed there was particular value in any appropriate initiative on health services ensuring clarity for European citizens about their rights and entitlements when they moved from one EU Member State to another, and in enshrining these values and principles in a legal framework in order to ensure legal certainty.

The health ministers also noted the increasing interest in the question of the role of market mechanisms (including competitive pressure) in the management of health systems. There were many policy developments in this area underway in the health systems of the European Union which were aimed at encouraging plurality and choice and making most efficient use of resources. They recognised that, while Member States could learn from each other's policy developments in this area, it was for individual Member States to determine their own approaches with specific interventions tailored to the health system concerned. Even if the principle of national competence in the provision of health services is unchallenged, the influence of European law is likely to continue to favour the application of Single Market legislation to health services. The European Council's 2006 statement on common values and principles underpinning EU healthcare systems listed

i The European Commission Directorate-General for Health and Consumer Protection, responsible for health policy.

them as universality, access to good quality healthcare, equity and solidarity. The proposed EU health strategy talks of citizens' empowerment as a core value:

> *Healthcare is becoming increasingly patient-centred and individualised, with the patient becoming an active subject rather than a mere object of healthcare.*[6]

The terminology used does not specifically feature the words 'consumer' or 'choice'. However, one of the strategic objectives is "supporting dynamic health systems and new technologies". Under this heading the White Paper speaks of e-health as helping to provide better citizen-centred care as well as facilitating patient mobility and safety. On mobility, it will be the Commission's still-awaited proposals in response to the consultation regarding community action on health services where the greater detail is likely to appear. But it seems that nothing in its proposals is likely to remove the impact of judgments on various aspects of the internal market and health services already delivered by the European Court of Justice.

8.7 Europe, UK health policy and intergovernmental relations

The Nuffield Trust's first *Devolution and Health* report[7] suggested that the operation of UK-level international health policy was one of the potential problem areas post-devolution, because of the strong desire in the devolved administrations to form direct health policy links with the European Union and other international bodies. The 2003 report[8] noted that major tensions over international health politics appeared to have been avoided so far, because the Department of Health, in its UK role, seemed to have worked reasonably well to involve the devolved administrations in EU affairs. There seemed to have been no major difficulties caused by the operation of the policy machinery relating to Brussels. However, the authors also concluded that in future the European dimension was going to figure much larger in the formulation of health policies within the UK. It suggested that the UK was going to have to engage more actively in discussing European health policy in the near future. This immediately raised a number of key policy questions, for the UK and the devolved administrations, and the report asked whether these developments would put new stresses on the policy process. It asked whether:

- European policy would 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 would that mean for the 'UK centre' and the devolved administrations?
- there would be a need to 'rebuild' the UK Health Department to address these developments?

That report commented that 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. It also commented:

> *Given the importance developments will have for the operation of inter-governmental relations, we might also ask whether IGR [inter-governmental relations] 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.*

In 2007, it seems that the jury is still out on both these questions, although in different ways. The continuing series of judgments by the European Court of Justice have imposed constraints on the UK, and the devolved administrations. Any regulatory instruments resulting from the consultation on health services might add further constraints. However, the health ministers' and the Commission's various statements that national health systems and their organisation should remain the responsibility of the Member States offers some reassurance that any impacts will not be major.

The second question now looks to be of great significance, given the advent of the Nationalist government in Scotland and a coalition government between Welsh Labour and Plaid Cymru in Wales. As discussed elsewhere, it is far too early to be sure whether the minority SNP administration can survive for its full term or how much of its policy agenda it can enact, given the need to obtain support from other parties in the Parliament. The One Wales agreement reached between the Welsh Labour party and Plaid Cymru appears to offer a good chance of the coalition surviving for its full electoral term.

In its first few days in power the SNP Government had already laid down markers about its wishes for the way ahead, These included a suggestion that Scotland should lead UK negotiations with the EU on fisheries policy (because Scotland has the biggest interest in the outcome of EU fishing negotiations, and it was logical therefore that it has the lead role). The Scottish government's desire for direct contact with Brussels had already been underlined. Alex Salmond, the new Scottish First Minister, also suggested the need for more formal channels of communication between Scotland and Westminster. Mr Salmond said the emergence of administrations in different parts of the UK, ruled by different parties, brought the need for channels of communication to be put on a more formal basis. He commented:

> *When you have administrations across the country of different political complexion, you have to have a proper process by which areas of joint interest can be progressed, areas of difference reconciled.*[9]

European issues clearly are one of the topics for which such processes might be used. At present, it does not seem as if issues within health policy or health services policy are likely to be the first to cause tensions in terms of internal UK intergovernmental relations, or of conflict over the UK policy line to take with respect to EU aspirations. This could change, particularly if any EU developments seemed likely to force further marketisation of health services, against the wishes of a particular devolved administration.

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9. CONCLUSIONS AND REFLECTIONS

9.1 Devolution and divergence

The former Secretary of State for Wales, Ron Davis, described devolution as a process, not an event. A phrase in common use more recently describes it as a journey not a destination. The Nuffield Trust's 2003 report was compiled when the UK was in the very early stages of that journey, but the authors hoped that it had been running long enough to enable identification of the 'trajectory' along which things were developing. A key question then was whether that trajectory was likely to change, and what might be the implications. Four years further on, during which time the devolution process has become more firmly established in the cultures and processes of the United Kingdom and the devolved administrations, is it any easier to answer these questions?

At one level, of course, it seems certain that there can be no turning back. Responsibility for health policy and the organisation and governance of the health services is devolved to the administrations in Belfast, Edinburgh and Cardiff and it is inconceivable that such responsibility would ever be returned to Westminster. The devolved administrations all appear to value their ownership of responsibility for their countries' health. In this sense, political devolution is a one-way street. Any future changes are more likely to involve the devolution of more powers, as has happened in Wales, rather than the pulling back of powers to the UK centre. Yet as events have progressed over the past four years, the complexities of asymmetric devolution have come more to the fore. Now that the details are being fleshed out, the devil in them comes to the surface. It is clear that, in terms of governance and organisation, the health systems of England, Northern Ireland, Scotland and Wales are now different in many ways. The language and terminology differs, as does the organisation. But how deep-rooted are these differences? Scratch the surface, and do all health systems start to look the same again? Are the key policy differences anything more than a superficial gloss on the same underlying set of activities – a continuing commitment to a health service free at the point of delivery, accessible to all and funded by general taxation?

9.2 Ends and means

The first Nuffield Trust *Devolution and Health* report raised the prospect of divergence among the health systems in the UK and, as the preceding chapters have demonstrated,

there is no doubt that differences have in fact developed. The governance and organisation of the health services in the four UK countries now differs significantly. Do these differences result from political devolution? Causality is always difficult to ascribe in complex systems, but it seems reasonably certain that many of the differences would not have been possible under the previous administrative devolution. For example, it would probably not have been possible for Scotland to abolish NHS trusts without the powers of the Holyrood Parliament, nor would the Welsh have been able to abolish prescription charges.

What we do not yet know is whether such 'headline' differences will become a permanent feature of the landscape, or whether there will be future convergence. Scotland was the first UK country to introduce a ban on smoking in public places, in January 2006, building on the success of the Irish Republic's initiative. Wales, Northern Ireland and lastly England all followed suit. The UK government initially proposed a less stringent ban in England than eventually was introduced, but the approaches being taken by the other administrations formed part of the argument for the eventual legislation. Significantly, if any UK country had tried to stand out against this trend, they would have been likely to find that in due course European Union action would have forced their compliance.

A current difference concerns prescription charges. These have been abolished by the Welsh Assembly Government, and their abolition was a manifesto commitment of the Scottish National Party, although it is not clear whether their minority administration will gain enough support to implement such a policy. A motion was introduced in the Northern Ireland Assembly in May 2007 asking the Health Minister to examine abolishing prescription charges. In replying, the Minister stated that the motion was entirely in keeping with his commitment "to see the flawed system, where some of our people pay for prescriptions, reviewed and changed". He announced that his officials would establish a review to inform a way forward. There appears no likelihood of any similar initiatives in England. It is interesting to speculate what the English response might be were the three devolved administrations all to decide to abolish prescription charges.

Such differences are important, but numerically are very much smaller than the similarities. As many commentators and analysts have noted, all developed economies are likely to face very similar health challenges. Langlands[1] lists six key challenges:

- the swing from the collective to the individual
- harnessing innovation in science and technology
- changes in the media and increasing political involvement
- the imbalance between demand and supply
- changes in the burden of disease
- the new professionalism.

Madelin[2] cites key challenges as including:

- the ageing population
- the impact of new technologies
- citizens' desire for more control over their own health

- availability of reliable health information
- the effects of globalisation and climate change
- new communicable disease threats
- consequences to health of lifestyle choices including diet, smoking and exercise.

Health inequalities, both within nations and between nations, are consistently cited as a cause of concern.

The United Kingdom is no different to the majority of Western European countries in this respect, and within the UK the particular challenges the devolved administrations face may differ in degree, but in essence are much the same. Each country can identify neighbourhoods or communities with particular legacies of ill-health, sometimes occupation- or deprivation-related, but there is still much in common. A great deal of the rhetoric in the different administrations' health policy papers is extremely similar, as the earlier chapters illustrate. And all four UK nations currently retain, and periodically restate or reinforce, the commitment to Bevan's founding principles of the NHS.

So what is the significance of the now common assumption that the UK has a 'family of health systems', rather than 'the NHS'? What is the real status of divergence among them? It seems clear that, at least to date, this divergence is not about ends, but about the means to achieving them. The forms of governance, organisation and management adopted are selected in the belief that they are the most appropriate way, in that particular jurisdiction, of achieving particular policy objectives – and in many cases those policy objectives are quite similar between administrations. The priorities expressed by the various administrations may differ, but these differences tend to reflect choices about the sequence in which issues should be tackled, rather than differences over the issues themselves: "Given that we cannot tackle everything at once, do we prioritise waiting lists or public health issues like smoking and diet?"

In the long run it is the ends that are important, and therefore any analysis of divergences or diverging systems should be based on their performance in meeting those ends, in terms inter alia of economy, efficiency and effectiveness. Where divergence exists in the approaches being adopted, it is important to be able to obtain the data necessary to permit comparisons. Although the complexity of cause–effect relationships will always be hard to untangle, and may limit the transferability of some lessons, unless some such attempt is made, significant parts of health policy will continue to be developed in a largely evidence-free zone.

9.3 Are we any nearer to knowing what is 'better'? Performance differences and the paucity of comparative data

Accepting that divergence is about means rather than ends, it is still important to know how effective the different means are. At present, despite now several years of operating with a family of health systems in the UK, there is still relatively little comparative data on

which to base any assessments of the impact on the health of the four populations. There have been differences in performance between the administrations, and some of these increased in the early years of devolution.

Waiting lists were a case in point. Leatherman and Sutherland's analysis indicated that in September 2004 England had the lowest number of people on the inpatient waiting list (16.9 per 1,000 population) and Northern Ireland had the highest (29.8).[3] In September 2004, the percentage of patients on the inpatient waiting list who had been waiting for more than six months varied from 7% in Scotland to 36% in Wales;[i] the percentage waiting more than 12 months ranged from 0% in England and Scotland to 13% in Northern Ireland. Longitudinal data from England showed significant improvement from 1999.

As the Auditor General for Wales noted in 2005[4] comparisons of the performance of the NHS in Wales with other parts of the United Kingdom were complicated by differences both of policy and in the way in which waiting times were measured. "Devolution produces different health priorities and approaches." He noted that the Welsh Assembly Government's policy had sought to focus on the wider determinants of health, social care and well-being in order to tackle the underlying problems that generate the demand which comes to the NHS. "As a consequence, there are differences in waiting time targets and priorities between Wales and other parts of the United Kingdom."

Nevertheless, the reduction of waiting times was an important element of the health policy of the Welsh Assembly Government and one of the main expectations of patients. The report found that:

> *Although Wales spends more on health per head of population than England, people living in Wales have to wait significantly longer for elective health treatment than those in England.*

The Auditor General found that the current waiting time situation in Wales was inequitable, both within Wales and in comparison to the situation in England and Scotland. Despite local actions and innovations which had contributed to improvements in waiting times, overall the NHS in Wales had not yet delivered sustainable reductions in waiting times.

> *This reflects the weaknesses in performance management arrangements, which have provided neither strong incentives nor sanctions to improve waiting time performance.*

He recommended that the Welsh Assembly Government lead the strategic reconfiguration of the capacity of NHS Wales, to ensure that the right services were available in the right place and, above all, within an appropriate waiting time. The situation in Wales did then improve, however. The Auditor General revisited the issue of Welsh waiting times in 2006[5] and was able to say that, shortly before the latest report was published:

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i Data on six-month waits was not available for Northern Ireland.

The Welsh Assembly Government announced an ambitious new waiting times target that by 2009 no patient should wait more than six months between referral and treatment, including diagnostics (the '2009 access target'). If achieved, this target would represent a very large reduction in the prevalence of long waiting times.

This had replaced the targets existing when the Committee had last reported, and which it had concluded were not ambitious: yet even they were not being met. The new total waiting time target was consistent with developments in England, where by 2008 it was intended that waiting times should be no longer than 18 weeks from GP referral to treatment. The Auditor General's 2006 investigation found that the NHS in Wales had made considerable progress in reducing long waiting times and addressing their causes within a clear strategic context. By March 2006, waiting times of a year or more had been virtually eradicated.

Scotland too had needed to address problems with waiting times. In 2006 Audit Scotland re-addressed the Scottish waiting time performance.[6] It concluded that the NHS in Scotland had made significant progress towards meeting waiting time targets. In doing so, it noted that the total number of people waiting for inpatient and day case treatment had changed little in the last two years. The number of people without waiting time guarantees had increased, and most of these patients had been waiting over six months. Together with changes in the way waiting time guarantees would be applied from the end of 2007, the trends suggest that the NHS would face a major challenge in meeting more ambitious targets in the future. Audit Scotland's report commented that comparing Scottish and English waiting times was complex, as current guarantees and future targets differed between Scotland and England. Having reviewed the detail of the different guarantees and the waiting time performances, the report suggested that Scotland performed better than England on inpatient and day case waiting times, but that Scotland had many more outpatients waiting over six months than England. However, it commented that differences in the way information was collected in the two countries made direct comparisons difficult and potentially misleading, although changes that were to be made in Scotland by the end of 2007 offered the prospect of closer comparison. In February 2006, ISD Scotland[ii] issued a technical paper which aimed to clarify one of the specific issues that received public attention, that of making comparisons between the median waiting times published in Scotland with the median waiting times reported in England.[7] The figures produced, which in the English case were converted to days in order to ease comparison, suggested that the considerable differential in England's favour in 2002 had been reduced significantly by 2005.

Other attempts have been made to compare the performance of the different countries. Many of these examine the treatment of particular conditions or diseases. One inter-country comparison, in stroke treatment, is offered by the National Sentinel Audit for Stroke, which is funded by the Healthcare Commission and carried out on behalf of

ii Information Services Division (ISD) is Scotland's national organisation for health information, statistics and IT services.

the Intercollegiate Stroke Group by the Royal College of Physicians' Clinical Effectiveness and Evaluation Unit. The audit covers 100% of eligible hospitals in England and Wales. In 2006, the 'headline' finding was that stroke patients in Wales were more likely to die from stroke, or if they survived would have higher levels of disability, than in England or Northern Ireland.[8] The Audit argued that the late launch of a National Service Framework in Wales in 2006 appeared to have handicapped the development of specialist stroke services in Wales, which needed urgent attention.[iii]

Bevan and colleagues have recently made a determined effort to track the performance of the different health systems in the UK.[9] They attempted to construct six sets of indicators relating to health, per capita expenditure, inputs, activity, rates of selected operations, and other outputs. They commented that, although in Northern Ireland, Scotland and Wales they were able to identify people who could confirm the accuracy of the data collected, "there seems to be no one who can do this for England". They further commented that:

> *We have been astonished at the difficulty, and in some cases impossibility, of obtaining valid comparable basic statistics on the NHS in the four countries.*

This fact is supported by Leatherman and Sutherland's study, cited above, which developed and reported indicators of quality using routinely collected data. This found only six indicators for comparing effectiveness across the four UK countries.

Since devolution in 1998, it appears to have become more difficult to collect comparable data across the four UK countries, particularly on NHS expenditure and waiting times. If they so wish, the different administrations can define, collect and publish information in different ways one from another, thus making comparison difficult or impossible. Despite the difficulties, Bevan and colleagues concluded that NHS activity and health outcomes seem more dependent on how healthcare resources were deployed than on higher levels of resources:

> *The data do not suggest that the UK countries with higher levels of real healthcare resources or expenditure have more activity, better population health, or higher levels of public satisfaction. Hence these outcomes may be more dependent on how resources are deployed and how factors outside the healthcare system influence health.*

Ham has examined the differences before and after devolution, which he divides into differences in NHS structures on the one hand and systems of national government on the other.[10] He comments that the different political governance arrangements have resulted in different power relations between politicians and civil servants, with concomitant effects on the ability of the devolved national health services to respond to local (i.e. national)

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iii The Audit noted the evidence for the benefits of stroke units and pointed out that only 45% of eligible hospitals in Wales had a stroke unit, compared with 96% of eligible hospitals in England. As a result, only 28% of patients in Wales were treated in a stroke unit during their stay, compared to 64% in England and 73% in Northern Ireland. The Audit concluded that Wales needed to identify systems to raise the quality of stroke across the whole patient pathway, but particularly through the development of stroke units.

wishes. Among other things, this had manifested itself in free personal care for the elderly in Scotland, and free prescriptions in both Scotland and Wales. Ham also cites the tendency in England towards more market-based solutions, including the increased use of private sector providers (for example independent sector treatment centres (ISTCs) and the establishment of foundation trusts.

In general discourse, England always seems to be the yardstick for comparison. If waiting lists in Wales are worse than in Scotland, for instance, it seems to attract less attention than if the differential is with England. There may be many reasons for this, including among them the relative size of the English NHS or the influence of the London-facing media. In the same way, if performance in Scotland or Wales is better than that experienced by English patients, it may attract attention and comment. As a consequence, the devolved administrations tend to be challenged to justify divergence by proving that their approaches work better (that is, achieve better ends) than those used in England.

The concerns about waiting times arose at least in part because the performance management regime used in the English NHS did lead to rapid improvements in the headline figures (although, as some have argued, at the expense of distorting other priorities). The problems in Wales and Scotland arose in part because of the wide performance gap with England, and in part because in absolute terms the waiting time figures were judged to be unacceptable. As a result, it appears that although initially the English NHS had improved its waiting time performance significantly, and significantly faster, than had the health services in Scotland and Wales, the latter countries then had to take steps to catch up. What this appears to mean for health policy is that there is a practical and pragmatic limit on the ability for policy to diverge, if such divergence is likely to lead to performance gaps. Different means are likely to be acceptable only as long as they deliver the same (or better) ends.

Politicians would like to be able to claim that their policies are most effective at delivering improved health outcomes and health service performance. At present the information does not allow such claims to be made with any confidence. If there was a more easily available set of comparative information describing the performance of the four health systems, it should produce a more informed debate about the relative merits of the approaches being taken in the different countries. Health professionals and managers presumably would welcome the development of such comparative data, even if some politicians might find some of the evidence inconvenient.

Unless and until there is more ‘whole system’ comparative data, there is likely to be the generation of a series of issue-by-issue debates about aspects of performance, particularly around ‘rationing’ decisions such as the availability of particular drugs or access to particular interventions.

9.4 The 2003 report revisited – still more questions than answers?

Jervis and Plowden concluded their 2003 report with a list of questions still to be answered as the monitoring exercise concluded. Revisiting those questions in 2007 indicates that many still remain to be answered.

- Will aspects of health and of health services in the devolved administrations become issues of contention in UK politics and especially in UK elections?

  The answer here is 'yes'. It is now clear that health issues will feature significantly in both national (devolved) and UK elections, despite the fact that the latter will not determine health policy in the devolved administrations. Recent general elections have shown that Westminster MPs from the devolved administrations have been reluctant to withdraw from their domestic health issues. One consequence of this not anticipated when Hazell and Jervis reported in 1998 has been the de facto development of a two-year electoral cycle in Cardiff and Edinburgh, with the consequent difficulty for administrations of pushing through radical or unpopular changes.

- 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 intergovernmental relations?

  As yet there has been little chance to judge this. Political devolution already has shown the potential for tension even with the same party in power in Westminster, Scotland and Wales – something that the 1998 report perhaps underestimated. As the previous accounts have shown, there are differences between Scottish Labour and Welsh Labour and the New Labour administration in Westminster. But the 2007 devolved administration elections have increased the likelihood of tensions developing. Already there have been calls for more formal and transparent processes of intergovernmental 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?

  There are now such differences, and already the pressure has begun to make the machinery of intergovernmental relations more transparent. If these pressures increase one consequence might be the need to address the difference between UK and English policy – in effect to address the 'West Lothian question' in the context of health policy.[iv]

- 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?

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iv The 'West Lothian question' was first posed on 14 November 1977 by Tam Dalyell, Labour MP for the Scottish constituency of West Lothian during a House of Commons debate over devolution. "For how long," he said, "will English constituencies and English Honourable Members tolerate ... at least 119 Honourable Members from Scotland, Wales and Northern Ireland exercising an important, and probably often decisive, effect on British politics while they themselves have no say in the same matters in Scotland, Wales and Northern Ireland?"

At present this seems unlikely. In most surveys health services emerge as extremely important to voters, with concerns addressed either about their current state or possible future developments. However, most survey data continues to show that patients express very high levels of satisfaction with the treatment they receive. Apart from particular 'rationing' issues, for instance the availability of particular drugs in different countries, devolution per se has yet to appear as a major issue.

- 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?

  This has been discussed in detail above. Although the devolved administrations are thought to be opposed to the 'marketisation' of healthcare services, all do in fact have the legislative ability and the legislation already in place to follow the English example. Whether pressure will increase depends in part on the devolved administrations ability to deliver performance improvement equivalent to England's without such approaches. European developments also may have a part to play here.

- 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?

  This and three subsequent questions about the English health system still await any further developments of the political devolution agenda within England. Since this has effectively been on hold since the rejection of the referendum in the North East they are not revisited here.

- 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?

  Again the answer is in the affirmative. The period since the question was posed in the 2003 report has seen the passing of the Government of Wales Act 2006, which "gives Welsh Ministers new powers to address Welsh issues in new ways".

- 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?

  The forthcoming European Commission proposals on patient mobility are likely to be important here. In practice, geography may well limit impacts in much of the UK. However, developments may be particularly important for Northern Ireland (the only part of the UK with a land border with another Member State) and the south-east of England with its easy access to France, Belgium and the Netherlands.

Four years' further experience of devolution in health has answered some of the questions posed in 2003, but equally new issues have arisen. At this point, is the 'divergence' trajectory now firmly established? The answer, perhaps to some people's surprise, may not be such a definite 'yes' as seemed the case in 2003. There is a contest going on between forces for divergence and those favouring convergence.

9.5 Future directions – divergence or (re)-convergence?

To this author at least, it is not easy to produce concise 'sound bite' summaries of the current situation. It seems harder to sum up the state of play today than it was four years ago, and the situation seems now to be more complex than previously discussed. Clearly, the fact that there are now governments of different political persuasions in each of the four administrations is a significant dimension of this complexity, but it is not the only one. Why does the picture seem to have become cloudier?

It may be, of course, that the previous research, commenting on the development of the 'family of health services', was too superficial, and too ready to ascribe deeper significance to what might turn out to be relatively superficial or short-lived differences – the rhetoric of devolved government hiding a continuation of centralising or standardising pressures. It may be that those were correct who argued that the differences being seen in the early stages of devolution in health had their origin in approaches formed during the previous period of administrative devolution. Another possibility is that, over the past three or four years, greater centralising pressures have developed than were present in the early (heady?) days of devolution. If this last suggestion is true, then one of the major sources of centralising pressure may be the most recent developments in Europe, discussed earlier, and the constraints these may in time place on the UK Governments' freedom of action – which in turn would be transmitted to the devolved administrations.

Adams and Schmuecker talk of a complex relationship between forces for divergence and convergence within the UK:[11]

> *Six years into devolution, we are starting to see some interesting shifts in policy and a complex relationship between forces for divergence and convergence in the UK ... . Despite assumptions to the contrary, divergent policies are not an inevitable consequence of devolution and there are significant countervailing forces for convergence in policy.* (p. 3)

The forces for divergence cited include policy choice within a permissive settlement; political parties and policy communities; and divergent rhetoric. The forces for convergence include public opinion; values and policy preferences; the common market; dominant narratives; and the lack of intergovernmental structures. Currently, where do these forces leave health policy, and in retrospect how sound were the conclusions of the earlier studies about devolution and health?

The Nuffield Trust's 1998 report talked about the potential for "innovation at the periphery" and speculated that the smaller administrations might prove to be highly innovative, and to offer models from which England could learn. The devolved administrations did take the lead in some areas, but these tended to be in public health rather than in health services. Scotland was the first to introduce its smoking ban in public buildings; Wales the first to appoint a Children's Commissioner. But in health services, in fact it was England that vigorously embraced the agenda of personalisation and contestability. Is it therefore, as some have suggested, simply that England has embraced the necessary agenda more rapidly than the devolved administrations? Has

political devolution offered a breathing space in which Scotland, Wales and Northern Ireland can stand out against some of the market-based approaches to which England is committed? Will the covert pressures encouraging the devolved administrations to move in the English direction increase? These pressures could include:

- financial pressures on public expenditure
- performance improvement in key areas being seen to be lagging behind that which is being achieved in England.

The issue of values is one that is central to the outcome of the trial of strength between the forces for divergence and convergence. There is a key dilemma here. The Nuffield Trust's recent investigations[12] speak of finding "some very different entrenched values" in the devolved administrations, and that the "broader process of European Union politics has produced a great diversity of values". Yet these findings stand in contrast to the European Council's assertion, accompanying its promotion of common values and principles in health systems, that there are "over-arching values" that are shared across the EU about how health systems respond to the needs of the populations and patients they serve. (Although they also note that the practical ways these become a reality vary significantly between member states.) Adams and Schmuecker include 'values' as one of the forces for convergence, not divergence.

There are other factors favouring convergence. The impact of the European Union in health may well be significant. The existing rulings of the European Court of Justice have already brought important consequences. Although health services were excluded from the Directive on Services in the Internal Market, they are services within the meaning of the Single Market legislation. The Commission's proposals on action to support patient mobility are awaited, and all Member States are now expected to respect the EU's common values and principles underpinning health systems in their policies. Although the various statements made so far have continued to stress that Member States remain responsible for health systems, and reinforce the principle of subsidiarity, it is at least possible that this may change in future. Might the point ever come when the values and principles come to be interpreted as defining a health (or health service) entitlement for EU citizens?

Another feature affecting the way matters develop is the interaction between policy areas which in the UK are clearly devolved (such as health) and areas which are reserved (such as the regulation of particular industries and professions). There are many complexities here – not least the need for communication and coordination between health departments and other UK government departments such as the Department for Business, Enterprise and Regulatory Reform (formerly the Department of Trade and Industry). In that market regulation issues generally are reserved to the UK level, and a major subject of EU focus, this is likely to produce a continuing and perhaps increasing pull towards centralisation and standardisation across the UK. The 2007 UK Government policy review of public service also implies a convergence of approaches.

Politics, of course, is central here. A mantra often repeated in the earlier Nuffield Trust *Devolution and Health* reports was that little real divergence could be expected while the

same political party was in power in all the countries of the UK. The (unspoken) thought behind this was of a future when the Conservative party might be returned to power in a UK general election, despite the continuation of Labour (or Labour/Liberal Democrat coalition) governments in Scotland and Wales. What no-one factored into these considerations was the possibility of a Scottish Nationalist government flexing its muscles within the United Kingdom, or a coalition government in Wales between Welsh Labour and Plaid Cymru. The impact of a Unionist–Sinn Féin power-sharing administration in Northern Ireland adds to this diversity.

It is too early to identify all the impacts of this political diversity, or indeed to forecast how long they might last. But the effect is likely to be significant, even in the short term, for the processes of intergovernmental relations and the conduct of UK-level policy. Already, as discussed earlier, there have been calls from the new Scottish Government for a more formal basis to intergovernmental discussions and more transparency over UK policy formulation. Representation of (possibly differing) national interests in Brussels is likely to be contested. It may be that one appropriate organisational response to this is to create a small, separate UK Health Department, with a UK-wide strategic role, giving equal weight to relationships with the health systems of all four countries, and visibly separate from the (English) Department of Health in Whitehall. So, as this account is written, there seem strong forces which will continue to support devolved 'ownership' of key policy areas, of which health is a central one, but at the same time there are perhaps equally strong, but different, forces which suggest that convergence of policy content back to a UK mean may be likely. Will the balance between these forces permit the continuation of the current trajectory or alter it?

9.6 Devolution in health – from 'doing business' to 'defining entitlements'?

Despite the pressures for convergence, it remains true that we now need to talk about the four health systems of the United Kingdom, rather than a single, unitary National Health Service. Yet the key issues all the administrations are tackling remain very similar, as are the values espoused by the health services of the four administrations. In terms of governance and organisation the different health services do have significant differences one from another. There is the scope and potential for major policy differences between them, but at present there are relatively few of these. The differences that exist stem from differing cultures, traditions, styles and possibly values, and from the particular requirements of national geography and demography. Political devolution has seen a move away from a 'one size fits all' approach to health services, if there ever was one applied equally diligently across the whole of the United Kingdom, to a situation in which policies are formulated and delivered in terms of local and national appropriateness, albeit an appropriateness that has a number of dimensions. It seems right, at least to this observer, that this should be so.

Yet, while the different health systems have developed and the institutions and processes in which they are embedded have grown in maturity, the number and strength of

influences for conformity also seem to have increased, as discussed earlier. Many of these influences are coming from outwith the health agenda. Developments in Europe are among the factors that have the potential to encourage more uniformity of approach.

As a result, it is hard not to conclude that the name of the game has changed subtly but significantly in the past few years, and may change again, given the results of the 2007 elections. When investigation of devolution and health started, the question was "Could there be differences?" and if so, "How would the different administrations coexist within the United Kingdom?" The question was about how well Westminster and Whitehall would learn to let go, as much as it was about the how the new devolved administrations would learn to take charge. The initial focus of attention was essentially pragmatic, about the processes of doing business in the new devolved landscape.

Now other, possibly more fundamental, issues may be coming to the fore, stimulated in part by the new political landscape within the UK. Will issues of rights, entitlements and voice become stronger, particularly in view of the moves by the European Union to give itself a role in health services, and given the importance being attached by the EU to its statement of fundamental values underpinning health systems?

Now the agenda is not just about doing business, although that remains important. It is about determining, in the context of health, what it means to be English, Northern Irish, Scottish or Welsh, and what health entitlements this brings. This may come to determine not only issues about access to health services, but health status itself. Disraeli said that "The health of the people is the first concern of Government". That comment is still as important as it ever was, and is reflected today in the salience of health issues in all the UK's administrations.

9.7 Last words

The most recent developments seem to position the devolution in health trajectory at a critical point. Devolution brings the ability to 'do things differently' and it is a journey not a destination. Health is one of the most visible policy areas (together probably with education and perhaps housing) where administrations strive to mark the differences they make for their citizens. Hence the importance of health issues in public discourse, their coverage in the media, the very large share of Parliament and Assembly time they occupy, and the share of the national budgets they receive. All health systems face major challenges, stemming in large part from the demographic and economic realities. There remains an urgent imperative for continuing innovation in the face of the challenges.

The last chapter of the first Nuffield Trust report was entitled "'Different', not 'better' or 'worse'?" The spirit of that phrase should continue to inform the way the four UK countries' approaches to health and healthcare policies should be viewed. 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 relatively very poor health status. In a crowded island, everyone has the

potential to make life more – or less – difficult for his or her neighbours. The need to share and learn as people tackle the important endeavour of raising health outcomes is stronger than ever. By attempting to illuminate the early steps taken on the paths of devolution in health it is hoped that the Nuffield Trust's various initiatives may have contributed a little to this process of mutual understanding and learning.

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DEVOLUTION AND HEALTH

Many commentators have argued that devolution in the UK offers a rare opportunity to observe the evolution of four health systems, each starting from a common base. *Devolution and Health* focuses on how the health systems in the UK's three devolved administrations have evolved, and how their approaches have differed from those in England, since 2003. Ten years after the inception of the Nuffield Trust's devolution project, the report describes the main features of health policy since that time and reports on conversations with senior health leaders and policy-makers.

The report concludes that there are indeed forces for divergence among the UK's different health systems, as the Trust's previous reports have found. But it also identifies a number of forces which might lead to their re-convergence, forces which may have become stronger in recent years. There is now a contest between the forces of divergence and convergence, the outcome of which is not clear.

The findings in this report suggest that the 'devolution experiment' is indeed an important one, both in ensuring that the UK's health services continue to evolve to meet local and national need, and in enabling all the UK's health services to develop or adopt good practice to suit the needs of their own populations. Published in parallel with a Nuffield Trust report on the values of the UK's health services, it is likely to be of interest to policy-makers and healthcare leaders across the UK, as well as students of healthcare and social policy.

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