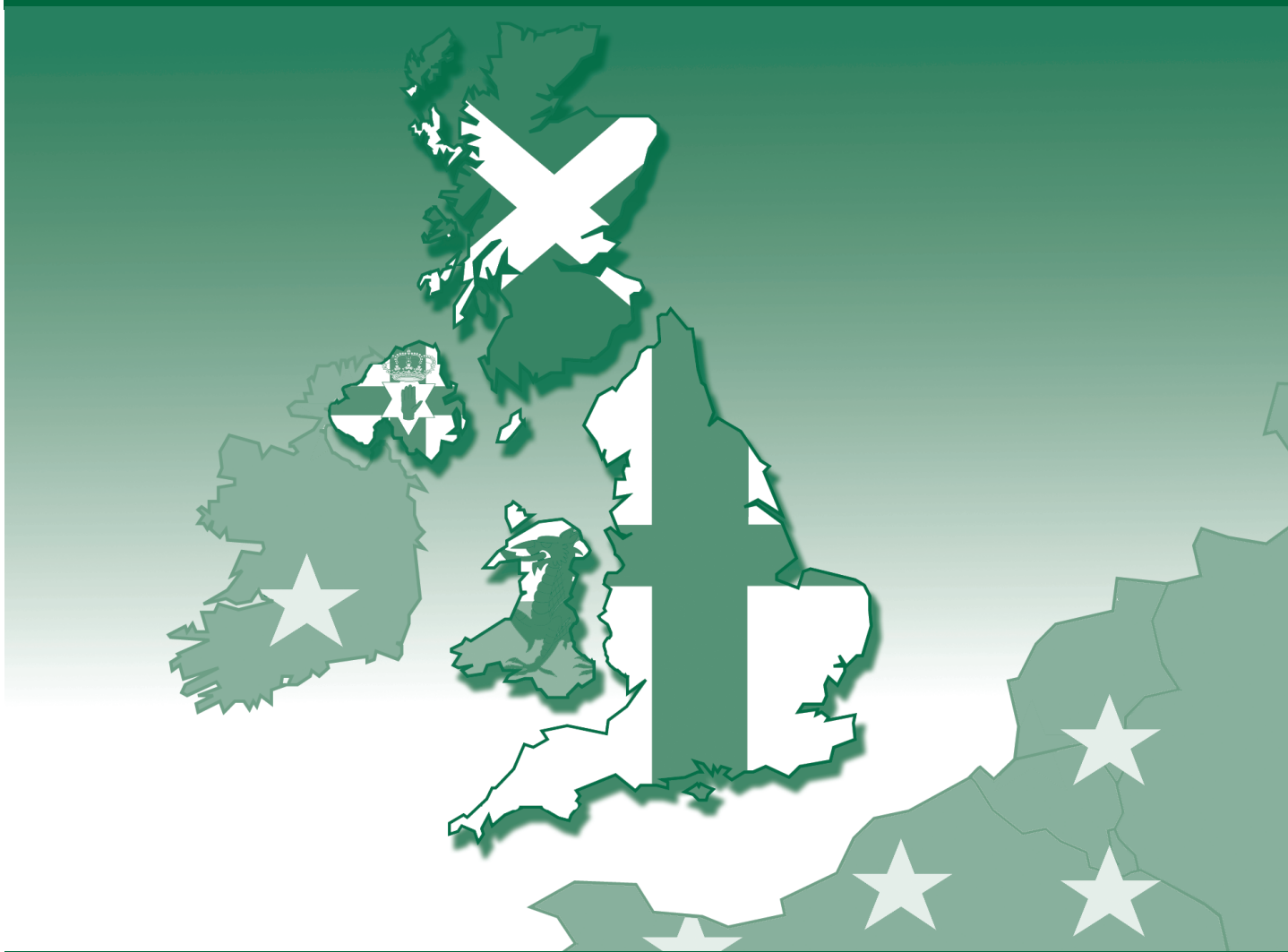
DEVOLVING POLICY, DIVERGING VALUES?

THE VALUES OF THE UNITED KINGDOM'S NATIONAL HEALTH SERVICES

Editors: Scott L. Greer and David Rowland



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FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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Contents

Preface

Values are important for the success of any organisation, including the NHS. They clarify what an organisation stands for, how it will use its resources and how it will make decisions. Both devolution and the increased role of the European Union in health policy pose new challenges to our health care system. What is, and should be, at the ethical and practical core of the health care systems of the UK?

This report, edited by Dr Scott Greer of University College London and the University of Michigan, and David Rowland, an experienced health policy advisor, aims to shape the debate about the *shared and divergent* values of the UK's NHS. It is based on a series of high-level seminars held in 2006 with policymakers of each country. These examined which values are encoded in the NHS and how they differ around the UK. The seminars also tackled the issue of which values are worth defending and promoting in the face of both devolution and 'Europeanisation'. The report focuses on the values of the NHS in each of the four nations that make up the United Kingdom, and those of health care systems within Europe. With reference to the UK it asks the question: "Do devolving systems lead to diverging values?"

We hope this report will make a significant contribution to the important debate of how we define the values of our national health services in the face of both devolution in the United Kingdom and the development of the wider European Community.

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Executive summary

This report is the result of a major Nuffield Trust project on NHS Values Between Devolution and Europe. The Trust, together with project partners across the UK, ran a series of high-level seminars discussing the values embedded in the health services and policies of England, Northern Ireland, Scotland, Wales and the European Union.

The different essays highlight some very different entrenched values, including 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'.

All are complex and under tension, but all stand apart from England in their commitment to communities and participation rather than markets and technical solutions. They also stand in contrast to the EU, which is in the throes of an ill-defined debate in which many different values are being put forth as guides to policy and more or less good descriptions of what might be shared between 27 countries.

As Rudolf Klein and the other authors note, there can be a tension between the values enunciated by policymakers and the ones revealed in practice. Tracing the connections is difficult, but to understand real values we must focus on the values revealed in the everyday lives of the health services.

The four UK health services emerge from common roots and common structures, so it is no surprise that the much broader process of European Union politics has produced a great diversity of values. The newness of EU health policy, further, means that the policies in which values would be encoded are still being debated. Here, where there is scant policy in which to seek revealed values, articulate statements of shared values are particularly likely to lead the debate.

UK political debates and political institutions have not recognised or adapted to the different values articulated by policymakers in different capitals. This creates problems for the stability of devolution, the autonomy of devolved governments to pursue distinctive values, and the compatibility of the UK systems with EU law. Better intergovernmental relations will help, but recognising the differences, while appreciating the extent to which values are shared, will contribute to more civilised debates.

Health care systems are driven primarily by values, not by economic forces.

Donald Light[1]

The concept of 'values' has become a recognized element in policy analysis, as reflected in WHO publications… . Yet research into the definition, operationalization and application of this notion of values remains underdeveloped.

V. Bankauskaite and R. Saltman[2]

Shared values are the bedrock on which the elements of our nation are built. Our values are given shape and meaning by the institutions that people know and trust, from the NHS to Parliament.

Prime Minister Gordon Brown[3]

1. INTRODUCTION: WHY DISCUSS VALUES IN HEALTH? WHY NOW?

Scott L. Greer
University of Michigan School of Public Health and University College London
David Rowland
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Values are a hot topic in health policy and Britishness is a hot topic in politics. There is no topic more value-laden, or laden with pronouncements about values, than health. And there are few institutions that have been more invoked, rightly or wrongly, in debates about Britishness, than 'the' National Health Service. So when Britishness and 'values talk' both surge to the front of debates across the UK, those who care about health should pay as much attention as those who care about devolution.

And to the front those debates are surging. In 2005 the World Health Organisation Europe updated its *Health for All* document with a special section on building values into healthcare systems.[4] In June 2006 the health ministers of the European Union signed up to a statement setting out the common values in EU health systems. For England, the NHS Plan document of 2000 for England contained a set of principles and values which are now in the process of being updated and revised by the Department of Health.[5] The new SNP government in Scotland (or, per the press release, Scotland itself) has been clear about some of its values, which do not include use of the private sector.[6] Finally, the new Health Secretary for England, Alan Johnson, announcing his 11-month review of the NHS, led by Lord Ara Darzi, gave it a remit that included the opaque:

> *The review should consider the case for a constitution of the NHS as the basis of a sustainable and lasting settlement that meets these challenges, enhances local accountability, secures value for money and protects the fundamental values that the NHS has always embodied.*[7]

The Secretary of State did not list the values. Rudolf Klein's contribution to this report suggests that might be just as well.

Values talk is coming to the surface now for two reasons. The first is that the governments of the UK are all dealing with contentious reforms and reconfigurations. Whether the arguments are high-level ones about the role of the private sector or local ones about maternity units, the language of health politics is the language of values. Governments, constantly accused of betraying the moral values of the NHS systems, also defend their decisions on the grounds of fidelity to, or modernisation of, those key values.

The other reason is that the latent instability in the devolution settlement is starting to show, just as it becomes clear that we can no longer pretend that devolution in health is all about local routes to a shared goal. The four political systems of the UK are different, as the 2007 devolved elections should have shown. Meanwhile, the end of the generous financial settlements of 2001–2005 means that it is more difficult to avoid explicit priorities – and hence clashes over these priorities. Just as politicians come to power who have less incentive to keep their arguments quiet, there is less money to grease the creaky wheels. And that means that there will be intergovernmental conflict and argument. That argument, potentially constructive, will be destructive if we do not all recognise one thing: *different systems make different choices because policymakers differ in the meaning and priorities they assign to different values.* Devolution is about not just different means but different ends.

"The latent instability in the devolution settlement is starting to show"

This project sites the discussion on values and healthcare systems within the politics of the United Kingdom in the post-devolution era. It is designed, in part, to elucidate the types of values which are being revealed through the current process of healthcare reconfiguration in the UK. This is a process driven not only by 'changing patient expectations', or technical change, but by the politics of the devolution settlement, whereby England, Scotland, Wales and Northern Ireland are fashioning healthcare systems specific to their politics, histories, populations and policy communities.

For a long time such a clear-headed discussion of divergent values could be put off. Before devolution, the stark differences in cultures, values and implementation mattered, but had only the territorial Secretaries of State to express them. Since devolution, stability came

because the Labour party was in government in London, Cardiff and Edinburgh, while it controlled Northern Ireland under direct rule. Labour's politicians, for all their differences, preferred not to create and exacerbate intra-party conflict, and they agreed on much. So the different values governments enunciated, and the ones they emphasised in practice, were not the stuff of political argument because the leading politicians chose not to argue about them. However, the elections of May 2007 and the restoration of devolution in Northern Ireland put an end to the pretence that values and practice had not significantly diverged – and that divergence did not have larger consequences.

Our assumption in this work is that an articulate discussion of shared and distinctive values is a good in itself that will help to shape and inform future politics and policy, for the good of both the different health services and for their autonomy in the devolution settlement. Articulating the shared values of health policymakers will make clearer the good reasons for what they do – if we know anything about the politics of the UK, or any other decentralised state, or international policy 'learning', it is that a respectful and nuanced presentation of other systems' values and decisions is painfully rare. Rather, others are used as handy foils or models to extol; consider the ease with which many European systems define themselves in opposition to a poorly understood US system, or vice versa.

Caricature of the other is not much of a problem when it is for domestic consumption. But it is a problem when political systems, such as the four political systems of the UK, are forced to explain themselves to each other, and outsiders, and argue. That is exactly what happens when there is a public outcry about perceived unfairness; or an intergovernmental conflict; or an argument about the incompatibilities between the European single market, the European social model and national models. An articulate discussion ahead of time, we hope, will help to make clear the stakes and channel the debate in intelligent directions.

The Nuffield project on NHS values between devolution and Europe

We approached the question through a series of seminars in the autumn of 2006, a time of calm before the potential storms of devolved elections and a new Prime Minister in 2007. We initially asked the speakers to address four questions:

- What values are encoded in the institutional design of the NHS?
- What values guide NHS politics, whether as shared goals or as taboos?
- What is distinct about the values of the NHS in each country (England, Northern Ireland, Scotland, Wales)? How does it relate to the country's history?

- What values are worth defending and promoting today – worth defending and promoting in a European context as health becomes increasingly an EU competency, worth defending and promoting as a shared UK value, or worth defending and promoting as a distinct value of the country?

Their answers, in short essays, were put to seminars held in London (for England) in October and in Edinburgh, Belfast, Cardiff and London (for, respectively, Scotland, Northern Ireland, Wales and the EU) in November. That timing is important. Even then, it was apparent that an epoch of devolution was ending: Prime Minister Tony Blair was on his way out, Northern Irish devolution was again starting to look likely, and Labour-led governments in Scotland and Wales had clearly consolidated their post-1998 policies just as their electoral prospects were eroding. So it was a time to look back, and a time to try to identify what is lasting and distinctive, and what will turn out to be a fluke of particular ministers or parties.

The seminars were an important part of the project. The attendees were a cross-section of health leaders and stakeholders in the NHS, including officials, professional leaders, special advisors, academics and other health policymakers. The discussions were initially started by a presentation from the writer, and they were focused on contributing to the essay so that the writer could speak in the knowledge that he or she reflected much informed opinion. The result is that the essays are not just statements by individuals about fields they know well; they are also the products of extended discussions between practitioners and scholars under the Chatham House Rule.

After the seminars, the writers updated the essays to reflect the views of the participants in those seminars, subsequent feedback and discussions, and, where authors deemed it necessary, new political developments. In such a project, it would have done a disservice to participants to impose a template, so each chapter reflects both the expert authors and the ways health values are discussed in various systems. The differing tones and contents reflect their ideas and the country seminars. They are based on the discussions, and attempt to reflect the assumptions, values, languages and tradeoffs of the four systems.

The essays are not, therefore, guides to devolved public policy. They are efforts to identify the values that policymakers really pursue – the values revealed in action, as Klein writes. Knowing the values encoded in a system is as informative as knowing its organisational structure (and values are much more likely to be long-lasting). Nor are they efforts to comment on the performance of the NHS systems; while there is a need for comparative research on devolved systems, and on the performance of health systems as a whole, the goal of this project was to identify and work out underlying values – to ask what is valued enough to measure, for example.

We hope they will make values debates in the UK more articulate – to clarify divergence and its real acceptability to the publics, to highlight what meaningful things are at stake in intergovernmental conflict, and to help shape the UK's participation in debates about not just EU health values but also the policymaking processes that might run contrary to the values of the health services of the UK.

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We start with our values – the values of a health service funded by all of us, available to each of us, equally, free at the point of treatment, with care based on our need and not our ability to pay. Those values are non-negotiable. They make the NHS unique – the institution that makes people proud to be British. They are a beacon of compassion and an ethic of care, of fairness and of social solidarity, mutual responsibility for one another, in times that so often feel harshly individualistic. In everything we do, in every change we make, we will not compromise those values. Indeed I go further, because I believe that the changes we are making are not simply consistent with our traditional values: they are the best way of securing our values in a rapidly changing world.

Patricia Hewitt, Secretary of State for Health, 2005[1]

2. VALUES TALK IN THE (ENGLISH) NHS

Rudolf Klein, Emeritus Professor of Social Policy, University of Bath

So there we have it. Whatever is driving the changes that are currently transforming the English National Health Service – and no lesser word than transformation will do – it is seemingly not a change in the *values* inspiring policymakers. So we have a puzzle, prompting a series of questions. What is the relationship between policy-making and values if a dramatic shift can take place in the former without any change in the latter? How useful is the notion of values as an analytic tool when it comes to explaining policy variations, either over time or between different jurisdictions? While values may only be a rubber tin opener when it comes to *explaining* change are they nevertheless significant as the language of *justification* for policymakers? If so, does their invocation represent a kind of moral path dependency, in which the initial choice of direction shapes everything that follows? (Note the use of the word 'traditional' in Patricia Hewitt's speech.) Does this help us to understand continuities across time, as distinct from disruptions, in policy? "Values are no policy straitjacket but there are certain choices they rule out," as Marmor has argued.[2]

"What is the relationship between policymaking and values if a dramatic shift can take place in the former without any change in the latter?"

The changing NHS

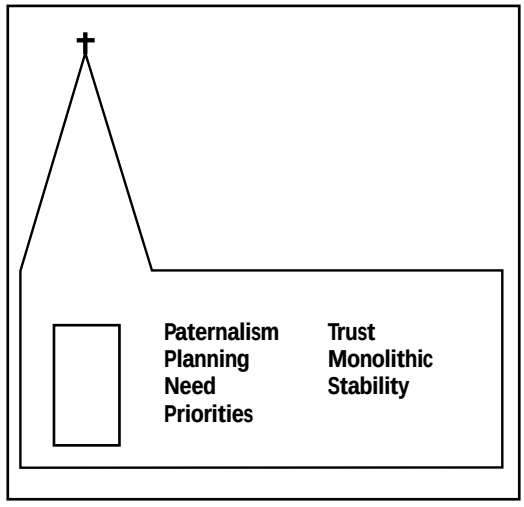
While policy rhetoric stresses traditional values, the institutional changes in the English NHS represent a break with the past. A 'trinitarian mimic' market model is emerging, based on consumer choice, a plurality of providers competing for custom and money

following the patient. Having created a command and control system in their first five years in office, successive Labour Secretaries of State spent the next five years chipping away at the structure. Power is to be devolved to the periphery; independent regulators will increasingly take over the supervisory role previously played by the central bureaucracy; the target-ridden, heavily directed English NHS is to become 'self-inventing'.

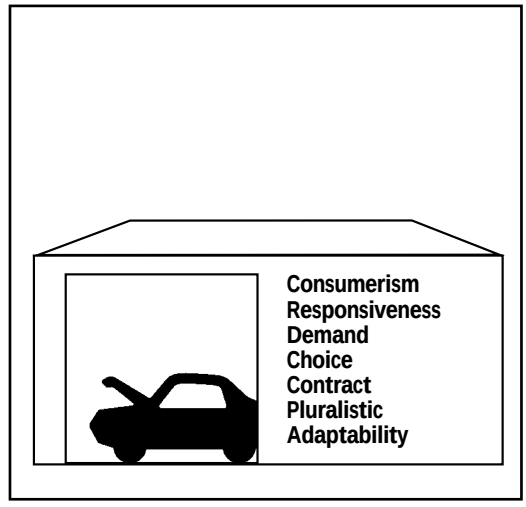
So much for the theory. How the model works out in practice remains to be seen, of course, and its drawing-board elegance will no doubt be greatly modified in practice. But for the purposes of this analysis it is not so much the institutional characteristics of the new NHS that matter as their intellectual underpinning: the changes in the way the policy community in the widest sense (academics included) has come to think about health care over the past 20 years or so.

I have tried to encapsulate the main elements in this intellectual shift by counterpointing the traditional way of thinking about the NHS as a church (Figure 1, Model 1) and the contemporary way of seeing it rather as a garage (Model 2). In each case, I have indicated what I see as the key words or concepts characterising each model (though my antitheses may be too neat and indeed my own hunch is that we will end up with a drive-in church).[3] None of these words or concepts appear in Patricia Hewitt's list of values, nor in other analyses of English NHS values (see Box 1 on page 25). But they do capture what I believe is a decisive shift in our collective 'appreciative system'[4] when thinking about health care, and not just health care. Here it is crucial to distinguish between policy goals and policy means. The move from the church to the garage model certainly represents disillusion with traditional policy tools but does not necessarily imply abandoning the traditional values that shape policy goals.

Figure 1: Two models of the NHS



Model 1 : The NHS as church



Model 2: The NHS as garage

To elaborate: introducing his legislation for the creation of the health service in 1946, Nye Bevan did not use the language of values. Neither, for that matter, did the 1979 Royal Commission on the NHS – a reminder that the proliferation of values talk is a relatively recent phenomenon. The master rhetorician contented himself with enunciating the principle that no one ought to be deterred from seeking medical help by 'financial anxiety' and pointing out that the NHS would "keep very many people alive who would otherwise be dead".[5] The implicit ethical imperative was subsequently spelled out by Barbara Castle, one of Bevan's disciples, when Secretary of State for Health in the 1970s: "Intrinsically the National Health Service is a church. It is the nearest thing to the embodiment of the Good Samaritan that we have in respect of our public policy."[6]

To achieve this 'embodiment of the Good Samaritan', the NHS as conceived in 1946 relied on a mixture of technocratic paternalism, faith in rational planning and trust in medical professionals to determine who needed what. It was these intellectual pillars that crumbled over the decades, as the ration-book society gave way to the credit-card society. Enter the garage model with its emphasis on consumerism, choice, responsiveness and so on. Does this represent a change in the English NHS values as set out by Hewitt and others? Or does it represent a rise in public expectations on the one hand, and a perceived failure of the church model to meet those expectations on the other, so leading to a search for new ways to meet traditional goals? Hewitt would certainly have taken the latter view, and I am inclined to agree with her. Moreover, in stressing the radical nature of the institutional changes, it is all too easy to ignore the very strong element of continuity: the fact that the English NHS remains a tax-financed health care service, free at the point of delivery.

On this interpretation, the real change in our 'appreciative system' has been in the way we think about the mechanics of public service delivery, as distinct from the goals. Hence the emphasis on introducing the dynamics of the market into the public sector, as well as using the private sector to supply public services. Whether this undermines or corrupts public sector values is another question, where the answer may depend largely on how we define those values and whether we think that they shape behaviour, and how, as distinct from rhetoric: knights, as well as knaves, have their pathologies.[7]

In all these respects, it is important to emphasise, change in the English NHS (as in other countries) is the by-product of wider changes in the way we think about public policy, which have affected all public services. In turn the way we think about public policy – the successive waves of reform starting with New Public Management – reflect wider changes in society: notably the shift from production to consumption as the centre of political gravity, as symbolised in the decline of organised labour. So one question to consider is whether this is as true of Scotland and Wales as it is of England: if the transformation of the English NHS reflects a transformation in the political culture of its environment, do

divergent directions taken by Scotland and Wales reflect distinctive local political cultures – that is, assumptions about appropriate mechanisms and tools of policy – rather than different sets of values?[8] Maybe the neo-Hegelian formula of the Third Way – reconciling what had appeared to be opposites and creating a new synthesis as between State purposes and market dynamics – has not caught on there. The reason for stressing the role of political culture, political institutions and political process is simple: the language of values does not translate directly into the language of policy-making, as distinct from policy justification. As Deborah Stone has put it: "Behind every policy issue lurks a contest over conflicting, though equally plausible conceptions of the same abstract goal. The enduring values are aspirations for a community, into which people read contradictory interpretations."[9] In short, to introduce the theme of the next section, values do not drive policy but are revealed in the process of making policy.

What do we know about values?

Values are a plasticine concept. There is little agreement about how to define a 'value' as distinct from a principle or a goal. Following Bill New's analysis,[10] a sensible working definition appears to be: 'values are conceptions of the morally desirable'. And his list of specifically English NHS values, filleted out by him from official documents, runs as follows:

- health
- universalism (compulsory cover)
- equity (social justice, fairness)
- democracy (accountability, answerability)
- choice (autonomy, freedom)
- respect for human dignity (honesty, consideration, fair dealing)
- public service (public service ethos, altruism, non-commercial motives)
- efficiency (cost-effectiveness, waste avoidance).

It is, conceptually, a very mixed bag. Some of the values appear to be about promoting desirable outcomes, like health and equity. Others appear to be primarily about processes, like accountability. Some are about ways of doing things that are desirable in themselves, like respecting human dignity. Others are about the means for achieving desirable ends: so, for example, efficiency would simply seem to be a necessary condition for achieving other goals, given resource constraints.[11] Some of the values cited by Patricia Hewitt, and not included in this list, appear to me to fall into the same category: so, for example, I would argue that 'free at the point of delivery' falls into the class of values, if indeed they can be called such, which are not intrinsically morally desirable but may or may not be a necessary condition for achieving others that are, such as equity.

End-state values tend to command universal support in as much as they have become the rhetorical platitudes of health care policy-making across countries. So, for example, the 25

Health Ministers of the European Union have agreed on the 'overarching values' – universality, access to good quality care, equity and solidarity – which, they claim, are shared across the EU, as well as a set of operating principles.[12] Everyone can subscribe to them because they are essentially abstract. As the EU ministers acknowledged, "the practical ways in which these values and principles become a reality vary significantly… and will continue to do so". Further, they conceded that "decisions about the basket of healthcare to which citizens are entitled and the mechanisms used to finance and deliver that healthcare, such as the extent to which it is appropriate to rely on market mechanisms and competitive pressures to manage health systems, must be taken in the national context". In short, value convergence is consistent with a large degree of policy divergence: policies cannot, for sure, be 'read off' values. Inevitably so, for values become contentious and fuzzy when it comes to giving them meaning in the process of interpreting and implementing them. What does equity mean in practice and how should it be measured? What is the role and responsibility of a health care system in promoting health? If such questions could yield a once-and-for-all answer, commanding general assent, there would be mass unemployment in the academic health care industry. However, there is no prospect of that. The instrumental values are contentious for somewhat different reasons. This is that their claim to be *morally* desirable often appears to rest on an (undeclared) assertion about causal relationships, and as such is vulnerable to empirical challenge. Do we know, for example, that abjuring profit motivation necessarily and inevitably contributes to respect for dignity or any of the other end-state, intrinsically desirable values?

Not only are values ambiguous. Not only do they yield many different, competing interpretations. But there is another reason yet for arguing that we discover our values – and the weight we attach to them – in the process of policy-making and implementation. This is that our values are often in conflict. There are trade-offs between them. For example, the existence of privately financed health care indisputably offends against the equity principle – that need should be the only criterion for allocating health care resources. However, abolishing privately financed health care would undoubtedly offend against the choice/autonomy principle as well as being politically dangerous (as Barbara Castle found out when she attempted to phase out pay beds from the NHS in the 1970s, a never-to-be-repeated policy experiment). Similarly, promoting health may come into collision with autonomy, raising questions about the extent to which the state should control individual behaviour and what relative weight should be given to the two conflicting values.[a]

a. For example, the recent case of an actor playing Churchill being banned from smoking a cigar on stage at the Edinburgh Festival suggests to me that in Scotland greater weight is given to the health promotion value than to autonomy; I would be surprised (and disappointed) if there had been a similar decision had the performance taken place in London.

A prolixity of values

So far I have been discussing what might be called big-picture, systems values. However, within systems there are nests of professional and other values. And again there is no reason to expect harmonious congruence. Most obviously, there is tension between managerial and professional values.[13] The clash of competing and conflicting values is apparent in the on-going debate about rationing. On the one hand, there are the values of the medical profession: these tend to rest on an ethical individualism, which stress the doctor's responsibility to do the utmost for the individual patient – for example, the rule of rescue. On the other hand, there are the managerial values (shared by many policymakers and academics) derived from a utilitarian calculus, which stress the cost-effectiveness of interventions not in terms of individuals but in their effect on the community of patients, actual and potential. Interestingly, the one point of near convergence appears to be agreement on process values: that decisions about rationing should be transparent, reasonable and publicly defensible.[14] This may suggest a more general conclusion: that process values are more robust – in terms of clarity and precision – than many other members of the value family.

Overall, the English NHS is remarkable for the explosion of value statements produced by its component organisations, in particular provider trusts. Box 1 presents two such statements (chosen because they are short, in contrast to the prolixity that marks most others) plus some individual examples. What these suggest is that the concept of 'values' is in danger of losing any precise meaning it might ever have had, and is becoming synonymous with any declaration of organisational ambitions, aspirations and goals, however general or platitudinous – who could object to striving for excellence, for example? Clearly those responsible for producing such litanies believe that they are useful in terms of defining an organisational culture and perhaps even shaping individual behaviour. Maybe they are. But it is difficult to resist the conclusion that – like organisational visions and mission statements – they also reflect managerial fads or fashions.[15] Such fads and fashion are not exclusive to the English NHS.

The English NHS – like the health care arena internationally – may be a particularly highly developed example of values introspection and proclamation. But it has no monopoly of values talk. The Civil Service, among others, has proclaimed its core values: integrity, honesty, objectivity and impartiality. Nor is values talk limited to the public sector. When the retiring chairman of the John Lewis Partnership gave a farewell speech, he entitled it 'Combining Established Values with Modern Retailing'.[16] Google gives more than a million references to values. Yet this appears to be a relatively new phenomenon in the case of the English NHS, as noted earlier, and perhaps more generally. This might suggest that values that used to be taken for granted are made explicit when institutions

have to cope with change: they represent an attempt to define the parameters of the acceptable and desirable in times of turmoil, moral lifeboats in rough seas.

Box 1. English NHS Trust Value Statements

Guy's and St Thomas', London

1. Put patients first
2. Take pride in what we do
3. Respect others
4. Strive to be the best
5. Act with integrity

St George's, London

- Treat all people with respect and dignity
- Deliver care in partnership with others
- Continually strive for clinical excellence
- Ensure probity and transparency in spending public money
- Be an exemplary employer
- Be committed to excellence in education, training and research
- Be open and honest with each other and those outside the organisation

"Balance technical excellence with consideration and compassion for those we serve" *Cambridge University Hospitals*

"We will recognise and celebrate the achievements of individuals, teams, departments and directorates across the trust" *Salisbury*

Concluding comment

Scepticism about values talk should not be taken for nihilism. To sum up the main theme of this chapter, my argument is not that values don't matter but that the starting point of any comparison of the four UK systems should be *revealed* values, not officially promulgated ones (which, I suspect, would not show up many differences). To repeat: values may constrain but do not drive policy. It is policy that reveals the meaning and weight attached to often ambiguous and conflicting values. For example, if equity is one of the professed values, policymakers are constrained, in as much as they would incur politically damaging charges of dishonesty and betrayal if they introduced measures that patently made access to health care more difficult for the worst-off. More than that, a

commitment to equity as a value is likely (at a minimum) to mean that other things being equal policymakers will lean towards measures likely to promote this goal: it establishes a presumption that policy will move in a particular direction. But it will tell us little (if anything) about the degree of enthusiasm that policymakers will show, the resources they will be prepared to invest or the instruments they will choose for achieving their goal.

In exploring why countries adopt different policies even while proclaiming the same values, one starting point is history. Even when countries share the same broad institutional framework (as in the case of the United Kingdom), policy-making styles may differ. For example, while in the English NHS relations between policymakers and professionals have become more antagonistic over the decades, the same does not appear to apply in the smaller UK countries. And if policy communities differ[17] then so may policy priorities or directions. Again, it cannot be assumed that the health services of the UK countries face exactly the same challenge. On the contrary: there is a relatively higher concentration of deprivation and ill-health in the peripheral countries, so it would not be surprising if different weights were attached to competing values. Similarly, the public in the four countries may have different expectations: the exit strategy of opting for private health care is very much an English phenomenon whereas loyalty appears to be the norm elsewhere. Institutions matter, too: proportional representation leading to coalition government is less likely to produce the kind of dramatic policy switches in the organisation of health care characteristic of the Westminster winner-takes-all system.

*"The starting point of any comparison should be **revealed** values"*

In exploring differences in policy outcomes the emphasis should surely, therefore, be on analysing the politics of values: the way in which institutions, coalitions of interests, established networks and ways of handling conflict shape the interpretation and implementation of shared values in the four countries. Above all, I would suggest, attention should be paid not to the values of the health care systems but to the ideas in good currency about the management of public services in the different countries of the UK. To the extent that many, perhaps most, so-called health care values are instrumental – means of achieving end-state goals – so the key variable may be notions about what are effective policy instruments. These notions may, in turn, depend on the context: small, homogeneous countries may have different options than large, heterogeneous ones. So different paths to achieving the same end-state values – whether in health care or in education – will be taken, depending on whether it is assumed that they can best be achieved by a strategy of co-operation and consensus or by competition and diversity: a judgement not so much about what should count as a good society as about what is best calculated to achieve shared ends.

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3. COLLECTIVISM AND COLLABORATION IN NHS SCOTLAND

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This chapter addresses the book's four shared questions about the role and meaning of values in the design and delivery of NHS systems:

- What values are encoded in the institutional design of the NHS?
- What values guide NHS policies and politics?
- What is distinct about the values of the NHS in each country?
- What values are worth defending and promoting today?

We also seek to address some of the important questions raised by Rudolf Klein in his contribution to this book. The first of these is about the extent to which there is a disconnection between values as a political concept and values as an organisational tool. The second question relates to why the founding values of the NHS, first articulated over 60 years ago, remain such an important aspect of the current debate about the NHS. This chapter seeks not only to describe what is different about NHS values in Scotland but to understand why these differences might exist and what this might mean for the models of service that are in place and those that are being developed.

Values in Scottish health policy

There is no doubt that the founding principles of the NHS remain part of the healthcare policy environment today, as the following extract from a recent statement by a Labour minister in the last Scottish Executive demonstrates:

> *The founding principles and core concepts of the NHS – comprehensive services, available to all according to clinical need, and free at the point of use – are part of our national fabric. These principles are strongly supported by the vast majority of the people in Scotland… these are our values. And we are committed to supporting and improving the NHS for the benefit of patients… . Our vision for the NHS is to apply its founding principles with vigour to meet the needs of the 21st century. Patients should be at the centre of the delivery of responsive care and treatment, with more convenient services delivered more quickly at each stage. Services should be as local as possible and as specialised as necessary.*[1]

What would the neutral observer make of this particular declaration of NHS values? The language is robust, as to describe the founding principles of the NHS as 'part of our national fabric' would appear to denote an interweaving of these collectivist principles into the warp and weft of Scottish life. To commit to apply those principles 'with vigour' to meet future challenges might be interpreted as suggesting that the commitment is for the long term.

The context of *Fair to All* was an announcement by the Minister of the setting of new, shorter outpatient and inpatient waiting time targets and a package of reform and investment. The key elements of that package, as set out in the Minister's statement to Parliament were:

- shorter waits for outpatients and inpatients (a new 18-week target to be achieved by the end of 2007);
- new targets for specific conditions (including the maximum four-hour wait target in A&E and a 16-week target for cardiac intervention);
- an end to availability status codes, to make waiting time definitions clearer and more understandable.

Mr Kerr revealed that these changes would be delivered by a combination of more care and treatment in the community, new roles for staff, redesigning services around patients, more capacity in the NHS, better IT, and engagement with the independent sector.

The reaction to this announcement was interesting. Few, if any, commentators questioned the underpinning values. Since the values in question are those around which the NHS was based, this suggests that those values remain widely shared. There was considerable support for the aims of the policy.

There was considerable opposition to one element of the delivery package, however. The strength of feeling about the use of the private sector is illustrated by the fact that, in the Parliamentary debate, one of the party spokespersons said that:

> *Mr Kerr is turning to the private sector out of desperation. That is a dangerous road to go down. The problem with that move is that it will be dangerous to the NHS and hard to reverse.*[2]

The amendment to Mr Kerr's motion to Parliament tabled by another party included the statement that the party in question:

> *considers private health care to be a parasitic drain on NHS assets, resources and staff that merely converts public money into private profit whilst undermining the founding principles of the NHS and threatens its very existence as envisioned by Aneurin Bevan.*[3]

This suggests a divergence between the apparently universal acceptance of the founding principles as distinct from what the application of those founding principles mean for healthcare policy and how services, for which the NHS will pay, will be made available to patients. There is no debate about what are the founding principles, or indeed about what they tell us about the desirable outcomes that flow from that value set (free at the point of delivery, equity of access, universal in coverage and so on), but there is a level of disagreement about how to achieve those ends.

As we move from the founding values to more recently emerging values, through outcomes and to delivery, we see an increasing degree of disagreement and discord. But what does an examination of what Rudolf Klein calls the 'revealed values' tell us? Revealed values are defined as those that might or might not be not officially promulgated but that emerge in the process of policymaking. One of the most significant pieces of policymaking in the NHS in Scotland was the development of the National Framework for Service Change. The resulting publication, *Building an NHS Fit for the Future* (or the Kerr Report as it is commonly known), relies heavily on a set of values developed by the advisory group during the course of their work.[4] The terms of reference for the National Framework include the following:

> *It will draw on a set of values underpinning the modernisation of health services: providing services in a consistent and equitable manner across the whole of Scotland*
> - *ensuring that the patient is at the centre of change, so that they get the treatment they require when and where they need it*
> - *removing barriers from the patient's pathway of care, and*
> - *working in partnership with patients, staff and other stakeholders.*

Clearly the language in this set of values owes something to the founding values. The notions of universality and equity remain evident. But they craft on to those founding

principles ideas about how patient-centredness, ease of access and collaboration interface with the original ideas of fairness. The emergent values recognise the importance of quality in a modern healthcare agenda in a way perhaps that the founding values did not. They also begin to reveal something about the importance of partnership and collaboration as part of the new NHS value set. The idea of jointly agreeing a care package between the patient is about collaboration. It might be argued that it is also about choice, but it is a different approach to choice than simply saying to the patient that there are four available hospitals and that they should choose one.

It is also interesting to consider what the development of the National Framework for Service Change revealed about the values of NHS staff and the Scottish public. The work undertaken for the National Framework review took place at a time when delivery of all aspects of Scotland's healthcare was under a media microscope. It seemed that almost every corner of Scotland suffered some bone of health contention, played almost daily through the regional and national press, from maternity services in the islands to hospital care in the lowlands. Although the detail differed for each example, the unifying theme seemed to be an unflattering comparison with the sense of momentum, rate of reform and perceived 'success' of the English NHS. A rather distorted image of Scotland's NHS was therefore reflected in a mirror held up by the media, health activists, policymakers and a few Westminster-based politicians. This fanned the flames of debate, further polarising opinion and fomenting a series of local action groups, implacably determined to oppose the health board's plans for service redesign. It was estimated that almost 250,000 Scots either signed petitions, marched or formed protective human chains around 'at risk' healthcare facilities, demonstrating the depth of national feeling. It was generally accepted that health had become Scotland's new 'poll tax' issue, a political touchstone. This then was the Greek Chorus which played throughout compilation of the report and was one of the reasons that compelled the advisory group to engage with citizens and NHS staff in a series of town hall meetings.

Hitherto, there had been a rather inconsistent approach to consultation with the public over changes in service delivery, which often left citizens feeling that they were offered a binary 'take it or leave it' choice and with a strong sense that the relevant decisions had already been taken. Given the number of health boards, serving discrete regions of Scotland, it was apparent that decisions by one board could affect patient flows in an adjacent region; therefore undertaking a national consultation was the most logical way of introducing the general principles underlying change. The premise being that if there was acceptance of these tenets across the country as a whole, this would lead to greater understanding of the strategic reasons compelling change locally.

If values are 'the conceptions of the morally desirable', then in 'town hall' events throughout Scotland and in discussions with frontline staff, the Kerr report team got a

first-hand view of the current values of those interested in the way in which healthcare works in Scotland. The values debate was about how services could be embedded in communities, how people could get access to those services quickly, how we could improve standards and drive up quality. People felt they belonged to the NHS and that the NHS belonged to them. They wanted to be involved and they wanted an NHS that was 'better, quicker, closer and safer'. These community meetings allowed a dialogue between the advisory group and interested citizens, which was used to modify and adapt their own thinking on reform. The level of debate was high and was characterised by a strong degree of antipathy towards the 'market-driven' health reforms which appeared to dominate England's NHS. The words used to over-simplify English values were *contestability* and *competition*. There was clearly a belief that standards had to rise, that the NHS was seen to deliver value for money but that to be externally competitive there had to be internal cohesion. It was deemed more important to integrate the service and break down the highly compartmentalised barriers that separate every level of the NHS (primary from secondary care, teaching from district general hospitals, speciality from speciality, profession from profession and so on).

It was difficult to see how the values driving NHS reform in England could be easily applied to Scotland, given her geography, although the endpoints of reform converged on the same deliverables: affordable, high-quality healthcare ostensibly free at the point of delivery. The concept of competition is particularly evident in the creation of foundation trusts, in which England's hospitals are recreated as if they were Italian city-states, each at war with the other, with all surrounding estates and communities dominated by the metropolis. Presumably, creating this individualism should allow the potential for the freedom of thought, expression and action necessary to drive up health standards, but is probably overly reliant on faith that the foundation trust will be sufficiently communicative and responsive to conform to the wishes of the wider health community. Adam Smith, one of Scotland's most thoughtful sons, founded the science of political economy, but even he would admit that although individualism implies freedom and the potential for social progress, in practice it can lead to concentration of wealth and power in the hands of the few and, at least theoretically, sow the seeds of disorder and social instability. This model was roundly rejected in open debate by the citizens of Scotland.

Collaboration and collectivism, the values of the Scottish health service

The value set which was thought to provide a more recognisably Scottish view of the NHS used a different couplet of words, *collaboration* and *collectivism*. This model of healthcare depends on a much more significant degree of cooperation between all elements of

healthcare than currently exists. So both approaches to reform require divergence from the current system, reasonably described as a half-way house of 'grudging collaboration'. At their extremes, in England, competition to improve standards could lead to fragmentation, whereas in Scotland, increased collectivism could lead to stagnation. The true outcome is likely to sit somewhere closer to the median for both approaches; on the one hand, the health service is so interdependent that fragmentation would be limited, and on the other, why shouldn't collaborative networks compete with each other? Collectivism has its basis, not in the common ownership of wealth, but rather common ownership of the means of producing wealth. Another famous Scot, Robert Owen, founder of the mills at New Lanark, held that one of the twin evils of industrialisation, namely competition, forced down the standard of life and set man against man. His model was to substitute cooperative control of industry in order that production might be maximised in the interests of all and the profit distributed according to need. Clearly, this is an optimistic approach, and depends on significantly enhanced cooperation between the different tribes or clans populating the health service, but is consistent with the data which the advisory group gathered during the 'Frontline Forums' which were held in parallel with the town hall events for citizens. Healthcare networks can only proceed if there is senior clinical and management engagement, otherwise as Thomas Hobbes wrote in *Leviathan,* "In the absence of government, no Arts; no letters; no society; and which is worst of all, continual feare, and danger of violent death; and the life of man, solitary, poore, nasty brutish and short".[5]

This suggests in the modern parlance that perhaps the NHS should have *a light management touch that encourages or liberates clinical teams to innovate in their own fields*. At risk of mixing further metaphors, we could contrast Darwinian evolution through competition with one of the anarchist Peter Kropotkin's statements that "the fittest are those species best able to achieve cooperation".[6] Here again is another point of convergence, in that evolutionary pressures can be applied to a species or group, favouring the potential for cooperation to adapt to changing environments.

So, we have two healthcare systems (in Scotland and England) that have started from the same place insofar as the founding values are concerned but which have moved in significantly different directions, both in terms of the coding of those values into policies and in terms of how those values have been adapted and revealed in the process of making policy. In Scotland the founding values of the NHS remain influential. However, they have been supplemented by a new set of co-existing values that are about involvement, community, quality, collaboration and collectivism. Each of these new values sits comfortably with the founding values. They do not challenge those original values but develop them. It was observed more than once during the development of the National Framework that we were going with the flow of the Scottish NHS.

In Scotland, there remains a strong sense that the values are shared, even as they have developed into being about quality and community, so the views of clinicians, managers and patients have remained compatible. There have been genuine tests of that compatibility and collectivism in the debates about the location of acute services. In such debates, vital concepts about shifting the balance of care can be replaced by arguments designed to protect local hospitals. But a broad consensus about the direction of travel has been maintained. Given the disconnect between values, policy and the healthcare system, there is a strong suggestion that there are a number of factors at play. In healthcare, values may play a stronger part than in most other areas of social policy. But nevertheless, the same set of issues is visible in health and healthcare that we see in so many other areas. Policy is driven by social and demographic change such as population ageing or variations in life expectancy, by the effectiveness of advocacy and by the choices made in the political process. Health policy has also been driven by the 'fit' it is able to achieve with the broader cultural dynamic of the time. Part of what was played back from the public in the conversations about the National Framework was a sense that health was an important part of local communities. It was about jobs, local economies and community confidence as well as about treatment and care.

"In Scotland, there remains a strong sense that values are shared"

Klein has said that "values do not drive policy but are revealed in the process of making policy". But policy is not something that is fixed in time. Policy (and politics) is a cyclical process and it seems likely, given the importance that ministers and politicians attach to values, that values revealed at one stage of the policy process are likely to drive how that policy is evaluated, reviewed and adapted. We may not see a linear relationship between values and policies, and a causal relationship is even more difficult to evidence. However, the remaining influence of an adapted value set in the consideration of NHS design and delivery suggests that values remain somewhere in the policy mix.

In a Scottish context, those values revealed by the public and by staff in the consultation exercise certainly helped to frame our report. It is stronger as a result.

Conclusion

Devolution has brought us an opportunity to test the worth of two superficially divergent value sets upon which the delivery of Scotland and England's national health services is based. Neither believes that the status quo is an option, nor that consolidation around a crumbling and defenceless sandcastle is possible. However, there is a dispute that the only answer to the 'intractable ineffectiveness' of the NHS is for a market-based relationship between hospital and patient. The next five years should give a clearer picture as to which

of these approaches delivers the health that our citizens demand and our nations need if we are to flourish fully in the 21st century.

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4. VALUES vs POLICY IN NHS WALES

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Discussions of 'Welsh' values and their policy implications have blossomed since devolution. In numerous political statements and speeches, the NHS and the assumed principles behind it have been ascribed a prominent role in an apparently distinct 'Welsh way'. This assumed trajectory includes commitment to communitarian and collective policies greater than in other parts of the UK. For the reasons discussed above, these statements cannot be taken at face value. Any credible discussion of 'Welsh' values and their impact on the development and future of the NHS in Wales has to identify what is tangibly distinctive about this 'Welsh way' and what is rhetorical window-dressing. One way of doing this, as Klein argues, is to look not at policy statements but at policy outcomes, using this to determine priorities, principles and orientations. We accept (and adopt) such an approach in our analysis below, but build on this to appreciate the potential impact of 'values' within the current Welsh context. If Wales was dominated politically by the Labour party as it was in the past, this might be unproblematic. But other groups have become more influential, and we cannot analyse their 'values in action' as they have not previously held power. We would not be discussing 'Welsh' values at all if we only discuss the attitude of Labour politicians and a progressive policy community. Opposition parties claimed nearly two thirds of the vote at the last Assembly elections. Their 'values' are thus of some significance. Given the paucity of research on these parties at present, we can only suggest that what has (or has not) been achieved by such parties in the past (at UK and at local authority

level) needs to be examined, alongside what they are currently discussing – in private as well as in public.

What becomes policy does not *necessarily* reflect commitments to a particular set of values. Policy options may be constrained by the political community's perception of 'public' or 'popular' values, which political actors may not wish to challenge for electoral reasons; they may be influenced by the views of an entrenched 'policy community'; they may reflect a health legacy which seems to determine policy concerns. Policy may also reflect central government targets or European requirements. 'The past' may thus influence policy options in the present, either because a 'Welsh' context has shaped their ideas or because there are Welsh constraints on new ideas. If opinion polls show that the middle classes in Wales are historically more likely to support collectivist parties than their counterparts in England, they also show that Welsh voters are as conservative as those in other parts of the UK – if not more so.[1] Perceptions of popular values may push politicians towards a 'common ground'.

Nonetheless, retrospective historical analyses of periods of apparent political consensus suggests that this consensus is often an illusion; that beneath apparently shared ideas and despite the use of common terms or policy tools, political actors often held different sets of values.[2] Thus even if we can identify apparent commitment to a set of 'Welsh' values or orientations towards the NHS, we should also expect to find that politicians may 'read' or present these values in ways which justify a variety of policy options. These deviations may at first gently challenge the 'core' ideals, even when made in their name; cumulatively they may undermine the core values themselves. The process of 'raiding' the values of the past to justify change in the present is less difficult (and more common) than one might think. Supporters of the NHS in 1945 did not hold to a single set of values or policy orientations, even if there were some shared concerns and ideas which had considerable support. Moreover, identifying a 'definitive' core of Welsh NHS values is particularly difficult. The NHS was a national (British) system, founded explicitly to *erode* differences in health care across the UK. Thus the capacity for there to be a 'Welsh' way which differed from the 'National' (Health Service) norm was consciously limited, almost as a matter of principle, from the start.

Of course, the introduction of the NHS did not abolish variations in health outcomes within the UK and both before and after the NHS was formed. Administrative devolution allowed for variations in policy which suggest that some values were more apparent than others. Since 1997, that capacity for policy divergence has been substantially enhanced, allowing for fuller expression of 'Welsh' values developed in the past. Since those who make policy since 1997 developed their political orientations in earlier periods, a 'Welsh way' can now evolve into more than a rhetorical device. We highlight the importance of

policy divergence in the final section of the chapter, recognising that different and competing policies may both be (legitimately) viewed as defending different aspects of 'Welsh NHS' values.

'Values-speak' in contemporary Wales

Few people can detect a neat transition from 'English' to 'Welsh' values on entering Wales. Nevertheless, references to 'Welsh values' within policy circles and political debate are now common. During the campaign for devolution and since the establishment of the National Assembly for Wales, politicians have frequently appealed to 'Welsh values' as a distinctive marker and as a justification for policy deviation.

Indeed, an appeal to 'Welsh values' has almost become a hallmark of true 'Welshness'. It is much used by politicians seeking to establish their credentials as representatives of Welsh opinion and by central government ministers charged with managing Welsh affairs – perhaps especially where their own policies are not particularly distinctive or are tied by the policies of a UK-wide party. Thus on 26 November 2002 Peter Hain, newly appointed Secretary of State for Wales in the Labour Government, duly addressed the National Assembly for Wales, declaring the need to protect "our very own and very special values in Wales… Welsh values of community. Welsh values of caring. Welsh values of family life. Welsh values of mutual co-operation and mutual respect. Welsh values of democracy. Welsh values of internationalism. Welsh values of multi-racialism."

Similarly, and after years of being seen as an 'English' party, the Welsh Conservatives have wrapped themselves in the flag. Under Nick Bourne the party started to adopt a 'redder' (more Welsh) hue.[3] The 2003 Welsh Assembly manifesto opened on health, with a clear commitment to a service which was universal, comprehensive, free at the point of delivery – and effective. Rather than proclaiming the value of private health care as a means to improve the service, it argued that unless NHS provision improved, people "will seek treatment outside the NHS, which will reduce the NHS' claim to be a comprehensive service".[4] Nick Bourne defended this departure from national policy emphases:

> *It is… important that the Party becomes more of an identifiably Welsh party… . In every case, of course, Conservative principles of opportunity, choice and freedom remained at the heart of our policies, but it was necessary to recognise there are important instances where there is a need to do things differently in Wales… . The importance of the community often makes Welsh needs different from those of our English neighbours.*[5]

There is a significant additional factor which is given too little attention in much social policy – (perceived) public values may structure both the expression and content of policy. After all, the primary aim of politicians is to get elected. Whatever the reality, in

the popular (Welsh) imagination the NHS is seen as a 'distinctly' Welsh policy. Attacks on the NHS may be seen as an attack on Wales itself or on people's own sense of what is 'right'. Particular historical forces have shaped people's beliefs and attitudes in Wales and given rise to a constellation of moral values and political allegiances, which may at times differ significantly from those held by people in England, Scotland or Ireland. Policy practitioners rooted in Welsh communities may reflect their traditions and perceptions. It could be argued that among patients, health services staff, administrators and politicians, there is a stronger sense of what Saltman has referred to as the 'social embeddedness'[6] of the National Health Service in Wales, for it is argued that it reflects deeply rooted values and norms. The innumerable references to Aneurin Bevan in political speeches, and to the Welsh miners' welfare system as a model for the NHS, is part of the process through which populist history has become a powerful contemporary influence. For example, in 1998, Alun Michael, then Secretary of State for Wales, enunciated Wales' special commitment to the principles of the NHS and adherence to the values articulated in the National Health Service in the preface to the policy document *Putting Patients First*:

"Swearing allegiance to Bevan's legacy is an important political gesture in Wales"

> *None of the values enshrined in the NHS when Aneurin Bevan created it will be lost. The NHS in Wales will continue to be a truly national service available to all on the basis of need. Need alone; not ability to pay; not who your GP is and not where you live. We will back those values by raising spending on the NHS in real terms every year.*[7]

Swearing allegiance to Bevan's legacy is an important political gesture in Wales. In an online poll in 2005 to find the top 100 Welsh heroes, Aneurin Bevan beat all-comers, ahead of the charismatic 15th-century hero of Welsh resistance to English rule, Owain Glyndwr, the singer Tom Jones, and the 'Welsh wizard' and architect of state pensions, David Lloyd George.[8] Bevan of course made the NHS the occasion of his resignation from the Labour Cabinet in 1951 – ostensibly because the principles of the NHS were challenged by the government's decision to introduce prescription charges and to require contributions towards the cost of dentures and spectacles. It is no coincidence that the Welsh Labour Party's commitment to free prescriptions was a leading platform of their campaigns on health. When Rhodri Morgan announced the abolition of prescription charges on 1 April 2007 he was making a clear political reference to the values so strongly espoused by Bevan.

Policy influences: health issues in Wales

'Values' – and policy orientations – may also be influenced by the health circumstances and the patterns and experiences of the past. A pattern of higher mortality and morbidity

was established in Wales well before the First World War. Wales had very high rates of tuberculosis and of maternal mortality during the inter-war years, with some areas in rural as well as in industrial South Wales being severely blighted.[9] It became an issue of grave political concern during the 1930s and a report prepared under the chairmanship of Clement Davies, Liberal MP for Montgomeryshire, laid responsibility clearly with the serious levels of poverty and social deprivation to be found in these areas.[10]

The problems of historic social deprivation remain substantial. There were, and still are, higher levels of poverty in Wales, in rural districts as well as in industrial areas, than in most parts of the UK. A study commissioned for the Welsh Assembly Government in 2005 found that 47% of the population earn less than £10,400, a seriously low income.[11] Employment in mining and steel manufacture declined rapidly during the late 20th century, leaving many areas suffering from high rates of relative deprivation.[12] The South Wales valleys have some of the highest concentrations of people suffering from long-term limiting illness in the UK[13]; people in Wales are more likely to report longstanding illness than those in England or Scotland (38% as opposed to 35% or 31% respectively).[14] Wales has the highest rates of child poverty in the UK, with 30% of families living below the poverty line, compared to 25% in England and 21% in Scotland.[15] Children in Wales are more likely to live in severe poverty than anywhere else in the UK, outside of London.[16] In some wards of the less affluent council housing estates (such as Tredegar Park, Newport and Townhill, Swansea) 80% of children are being raised in poverty.[17] There are higher levels of child obesity in Wales than the rest of the UK, with one in every four three-year-olds being overweight or obese.[18] This has serious implications for future rates of diabetes and heart disease, which are already high in Wales. Many other problems facing the health services are magnified in Wales. Crude death rates in Wales are the highest in the UK. Cancer death rates are higher than in England, as are death rates from circulatory and respiratory diseases. Wales has the highest number of prescriptions dispensed per patient in the UK – and some of the largest GP lists. The demographic pattern puts greater strain on health services in Wales, as a higher proportion of the population are over 65.

These concerns may suggest that there are particular health priorities, which themselves suggest particular policies. For example, choice in health care – a feature of Labour's UK-wide agenda – may seem less significant to health professionals and some politicians faced with communities for whom economic choices are not an everyday reality.

Policy influences: the historical response to Welsh health issues

Unlike Scotland or Ireland, Wales does not have a long history of separate legislation for health services and provision. Most Acts of Parliament in the field of health and social care were for 'England and Wales'. This has determined the policy context for welfare

provision as for health. Wales operated under the same Poor Law legislation, although some differences can be seen throughout the 19th century.[19] An element of devolution in regard to health dates back to Lloyd George's Health Insurance Act of 1911, which established a separate Insurance Commission for Wales. This was succeeded in 1919 by a Welsh Board of Health, which continued to administer health matters in Wales until 1969. Then responsibility for health was transferred to the Welsh Office as part of a new wave of devolved powers.[20] Bold plans for a distinctive Welsh health service, designed to meet the particular needs of Wales, were drawn up by the Welsh Consultative Council between 1920 and 1925, but were never implemented. Nonetheless, attempts to downgrade the limited influence of the Welsh Board of Health were seen as an (English) 'insult to Wales' and were strongly resisted.[21] 'Policy' may not have been that distinct, but people wished it to be a 'Welsh' way.

Prior to the establishment of the National Health Service, hospital services were provided by either private or voluntary effort, with some workhouses and poor law institutions developing sick wards and hospitals. These were transferred to local government control in 1929. Whilst there was a patchwork of provision in the UK as a whole, in Wales hospital provision was much less comprehensive than in either England or Scotland. There was not the tradition of large voluntary hospitals that grew up in England and Scotland, nor were there any large teaching hospitals. The University of Wales College of Medicine was a relative latecomer. There were large poor law institutions in towns such as Newport and Bangor, but many small market towns were served only by cottage hospitals, funded by voluntary effort. Generally in Wales, there were fewer hospital beds per head than in England, and fewer hospitals.[22] There were far fewer specialists in Wales, and patients requiring specialist treatment had to travel to Liverpool, Bristol or London. The War-time Hospitals Survey recorded with amazement that services taken for granted in England were absent in large areas of Wales. The provision offered by some smaller boroughs and by the rural and non-Labour areas was an embarrassment (indeed, a crime) in the eyes of many Welsh Labour figures. The NHS was a (collectivist) response to the neglect of the people by a Welsh (non-Labour) elite of coal owners and farmers.

Administrative devolution

With the establishment of the National Health Service in 1948 a regional hospital board was created for Wales (rather than attach north Wales to the north-west of England and south Wales to the south-west of England). The Welsh Hospital Plan of 1962 laid out a system of district general hospitals to serve the different regions of Wales, alongside the existing patchwork of smaller cottage hospitals and former municipal institutions. A number of large new hospitals were built, including Singleton Hospital in Swansea, Ysbyty

Gwynedd in Bangor and Wrexham Maelor Hospital. These have formed the backbone of provision ever since. Nonetheless, the general structure of policy was decided in England. Whilst health became a devolved responsibility in 1969, Welsh Office ministers battled to achieve this concession during the Wilson government, rather than developing their ideas on what to do with policy once that concession was achieved. Equally, much Welsh Office time after 1974 was taken up with the battle for political devolution and with cuts in expenditure, rather than with Welsh refinements to health service provision.

Conservative governments were hardly pioneers of a 'Welsh way'. From the 1970s to the 1990s, the party leadership showed little enthusiasm for state-owned public services and the communitarian sentiments said to be at the heart of 'Welsh values'. In the 1970s, the Conservatives' Welsh Policy Group was implacably Unionist. Peter Thomas also argued that there was little enthusiasm for devolution outside the Welsh-speaking (or chattering) classes, claiming that the people of Wales would benefit from integration with UK policy, not from the capacity to be different.[23] Nicholas Edwards certainly wanted greater powers for the Secretary of State for Wales – but over agriculture, an area where votes could be won, not health.[24] "The problems of Wales," stated the Tory manifesto at the 1979 election, "are very much those of the United Kingdom as a whole." This meant that the Welsh public sector was to be reduced and reformed. Convinced that the 'policy elite', including the Civil Service, would oppose these aims, the Conservatives were determined to draw on outside support to restrict their influence.[25] Of course, there were Welsh Conservatives who did not entirely agree. Wyn Roberts, Minister of State at the Welsh Office, appears to have dissented in private from the devolution policies, but in public even he supported a version of the party line.[26]

In the mid-1980s, under Peter Walker and David Hunt, Wales differed from the UK policy line in several spheres. John Wyn Owen, appointed as Director of NHS Wales in 1984, attempted to pursue a distinctive policy path more attuned to the needs of Wales. This included a pioneering attempt to improve the health status of the Welsh people and to develop service plans accordingly, including the well-known *Strategic Intent and Direction*, a guiding document for a distinctive Welsh approach to health reform.[27] Wyn Roberts used his influence with Margaret Thatcher to argue for a distinct Welsh cultural policy, conflicting with the business community and other British government ministers over the need for first a Welsh language television station and then a Welsh Language Act.[28] But there was no nascent 'Welsh (Conservative) way', struggling to get out. John Redwood, as Secretary of State under John Major, was much less enthusiastic than his predecessors about state support for public services. If Redwood frightened some Welsh Tories, others admired his clear and logical vision for building a 'new' Wales free from the (socialist) values of the past. The language of conservatism under Redwood was the language of the

consumer and the private sector, of disdain for 'Welsh' traditions which he felt had dragged the country down.[29] Either through loyalty or conviction, many Welsh Conservatives toed the Thatcherite line.

Health policies since 1998: the challenges to 'Welsh values'

Despite the limits to Welsh policy independence in the past, many of those involved in Welsh health policy since 1997 believe they inherited a distinct Welsh policy orientation. During the Nuffield Trust sponsored discussion that took place in Cardiff in November 2006, policy practitioners claimed that their Welsh past created values which permeated their own actions and understanding of policy options. This ranged from an uncomplicated notion of 'fairness' (chwarae teg) to a strong belief in a Welsh communitarian tradition which inspired the universalism at the core of Bevan's National Health Service. It is clear that this policy community is more committed to these traditions and collectivist ideas than its British counterparts, rejecting key elements of a more individualist and market-focused strategy. For example, BMA Wales came out strongly against the Private Finance Initiative (PFI). But we should not assume that all potential advisors – at UK or at Welsh level – think in the same way. As the attitudes of Welsh GPs to out-of-hours services and the attitudes of dentists indicates, not all Welsh health service professionals will tolerate an old-style NHS system.

Political devolution was viewed by many within the policy elite as an opportunity to exercise direct control over health policies in Wales and to tackle issues in a way which addressed the country's pronounced and particular health problems. On 1 July 1999, all functions previously exercised by the Secretary of State through Welsh departments were transferred to the National Assembly for Wales. As roughly half the total Welsh budget had been spent on health since the late 1960s, there was a sizeable amount of funding. Social justice, and participative and consultative democracy, was high up the policy agenda.[30] The White Paper *Better Wales* set out the overall programme. This was followed by a document specific to health entitled *Better Health: Better Wales*. This set out a strong public health agenda, aimed at improving the health of the Welsh people and reducing health inequalities. It saw health improvement as a key social investment designed to improve quality of life and deliver a 'Better Wales'. It has been described by Greer as an intellectually coherent agenda, which recognised that many of the health problems experienced in Wales were the product of economic forces and lifestyles, therefore requiring a much wider approach to their solution.[31]

A ten-year plan for health services in Wales focused on public health and primary care. It included proposals for a restructuring of health services, with the abolition of health authorities in Wales and their replacement with 22 health boards. This was meant to address

needs on a local basis and to co-ordinate the work of GPs and other health care professionals, representatives of social services and the voluntary sector to achieve a seamless service between health and social care.[32]

The espoused commitment to a more egalitarian Wales, with health services designed to be inclusive and to meet the needs of poorer, needier communities, led to an invitation to poverty expert, Peter Townsend, to prepare a report on health inequalities in Wales. The report was meant to form the basis for a re-allocation of resources to needy areas, with enhanced health provision compensating for the unfair burden of ill health experienced in disadvantaged communities. Yet initial plans to implement a new funding formula met with stiff opposition. It was realised that the formula would lead to a huge diversion of resources from north and west Wales to an area within a 25-mile range of Cardiff. The proposal was redrafted, with a 'rurality' measure included, in recognition of the higher cost of providing services in rural areas. This counterbalanced the extreme effect of the resource allocation review. Balancing the needs of rural and industrial Wales has always been a difficult political issue. The emphasis on health improvement and social justice was at the core of espoused Labour policies on health. According to Michael Sullivan, the Labour administration in Cardiff held true to the values of 'Old Labour' in that it was committed to the welfare state "as an engine of equality, social solidarity and free services". However, it went beyond this in fusing "an Old Labour tradition with a renewed quasi-syndicalist impulse, rejecting consumerism and individualism". Welsh health policy was driven by "a sort of twenty-first-century collectivism".[33]

Yet in amongst the talk of collectivism there were some strands of policy that reflected a concern with the rights of individual patients. A *Health and Social Care Guide for Wales* (2002) replaced the Conservatives' *Patients Charter* (1996). This policy document differed from the *Patients Charter* in that it covered health and social care. It took a rights-based approach and set out what people could expect from health and social care services. In line with its emphasis on 'inclusiveness' it was issued in eight ethnic minority languages and made available on audio tape and in Braille. It was aimed at both patients and carers. The potentially individualist language of 'consumer' rights has also been given a particular Welsh favour. A 1996 report defined use of the Welsh language as a crucial issue for consumers.[34] A key policy document, sponsored by the Welsh Language Board, took this further. The Welsh policy process combined to push a distinctive Welsh agenda.[35] There was strong recognition of the need to recruit Welsh-speaking staff and to allow patients the opportunity to receive health care through the language of their choice. A commitment to bilingualism is embedded through the content of antenatal and childcare classes and in nurses' training.

The emphasis on patient and public involvement, and on mobilising people to take greater responsibility for their own health care, was enshrined in the policy proposals

entitled *Signposts*.[36] This policy innovation was in line with the Assembly government's emphasis on 'active citizenship.' Similarly *Designed for Life* – a blueprint for the future of the NHS in Wales – was firmly based on the principle of bringing health care closer to the community.[37] It aimed to provide as much care as possible within the home – keeping patients out of hospital altogether or treating them on a day care basis where necessary, and using the resources released by this to improve the hospital system.

This too builds on solid Welsh traditions. Traditionally, Wales has had a low proportion of women in full-time employment, creating a relatively larger reserve of women available for caring. The emphasis placed upon family care and the vital role of wives and mothers in providing daily care for children, the chronically ill, disabled and the elderly, meant that a great deal of health and social care in Wales was provided within the informal sector. It also reflected the status of women as 'natural' homemakers and carers, and the cultural stereotype of the 'Welsh mam'. If this was hardly unique to Wales, it took a particular form – and one sustained by conceptions of Welsh national identity.

Tensions in policy since devolution

Nonetheless, the relationship between 'Welsh values' and policy has become more complicated. So far as women are concerned, 'Welsh values' have not been unchallenged. There is a new recognition of the role of women and of the economic value of unpaid care. Hywel Francis MP introduced a private member's bill in 2004, setting out statutory legal rights for carers. At the same time, the right to work – and to independence – has become a 'universal' value, strongly argued in Wales by the female contingent within the Welsh Assembly Government and by women in the Labour party – often against strongly entrenched male values. Thus contradictory pressures are simultaneously placing greater demands on 'home care' for the elderly and chronically ill, whilst encouraging women to play an economically active role in the workforce.

Other pressures have tested the sustainability of 'Welsh values' as a guide to Welsh policy. Following his report to the Chancellor of the Exchequer in April 2002,[38] Derek Wanless was invited to advise a project team set up to review health and social care services in Wales. Additional resources were being ploughed into health services throughout the UK and there was an urgent need to set priorities for expenditure. Wanless noted that the "current position in Wales is worse than in the UK as a whole, reflecting trends over decades" and argued the need to take a "long-term view".[39] The Wanless Review (2003) concluded that the current system was unsustainable and that a reconfiguration of health services in Wales was an urgent priority. The team identified unacceptable pressures on the acute sector and recommended "adjusted roles for social, primary and secondary care". They recommended making "bed equivalents available"[40] in order to relieve pressure

on the acute sector. Wanless also argued that individuals and communities needed to take greater responsibility for their health, and that a strategic adjustment of services towards prevention and early intervention was necessary. It identified serious weaknesses in the estates and infrastructure, in training and retention of staff and in information and communication technology (ICT). The Review proposed a greater role for primary care and emphasised the potential to transfer much 'health care' to the social care sector. Without adopting such a radical approach, it was argued, the acute care sector would soon collapse into chaos.

This stark warning introduced a new sense of urgency to health policy discussions, particularly as it was published at a time when waiting lists for hospital beds were building up. There was visible evidence of 'crisis', with daily reports of operations being cancelled, ambulances queueing to deposit patients in hospitals, and reports of 'bed-blocking' by patients ready for discharge but with nowhere to go. Jane Hutt's earlier assumption that the secondary care sector was well regarded and in good order, now seemed ill-advised. By September 2003 it had emerged that over a thousand beds were blocked, a third of them because of delays in providing social care places. In order to alleviate the situation Jane Hutt awarded an extra £4 million to local health boards to tackle the problem. Some improvements occurred, but waiting lists for hospital places remained stubbornly long.

Despite being under tremendous pressure, the Labour administration in Cardiff held fast to its opposition to use of the private sector and rejected the option of establishing foundation hospitals in Wales or of using private finance initiatives. Rhodri Morgan drew a line of 'clear red water' between England and Wales, arguing that the people of Wales had different values and priorities and that 'choice' was less important. "Our geography does not encourage this social model, and I don't think our values encourage this model either," he said. Instead, the government of Wales was committed to "collaboration not competition".[41]

Former Welsh Office Minister Jon Owen Jones claimed that if reforms were not initiated, the 'National' element of the NHS could easily be undermined. 'Welsh' values included a commitment to services which were comparable to those elsewhere. The idea that (Welsh) people should not have worse health, or wait longer for treatment, because Wales has greater health problems and limited resources is probably as strong as any other Welsh value. He launched a bitter attack on Labour policies, claiming that devolution had not delivered any advantage to Welsh patients.[42] He proposed charging local authorities for the cost of delayed transfers from hospital, and using PFI to build new hospitals in Wales. The National Assembly's audit committee expressed alarm at spiralling debts in the health service.[43] The deficit for 2002/03 was almost twice that of the previous year, despite an additional £500 million being put into the health budget. There were some underlying

factors, such as the rising cost of clinical negligence claims and a rapidly increasing drugs bill, but the worsening financial situation was of grave concern, and the Assembly Minister for Health and Social Services came under increasing pressure to change direction.

Under growing political pressure, and with a highly critical report from the Welsh Audit Commission about to be published, Jane Hutt was removed from office. The position of Assembly Minister for Health and Social Care was assumed by Assembly member and long-serving GP, Dr Brian Gibbon. He was charged with setting up a 'world-class health service'. He set about preparing a new strategy for re-organising the hospital services in Wales, and ordered a strategic review of health services. He set up three working parties to consider the shape of services in south, west and north Wales. Members were told that the objective was to engage, if necessary, in 'blue skies thinking' in order to re-shape the hospital services for Wales, making Wales a world leader in 21st century health care. There was much discussion regarding the unsuitability of the old district general hospitals to meet this requirement. Attention was also paid to the need to site community services within the framework of a shift towards social care for the treatment of chronic illness. Specialist tertiary services were not part of their remit. In line with the Labour administration's emphasis on public consultation and democratic process, a series of public consultations was built into the planning process.

The need for restructuring was seen as urgent. Andrew Butters, project director for the review of secondary care, spoke of the growing pressures on the hospital system, including the rising demand for hospital services, changes in staff terms and conditions, the need to meet improved access times set by the Assembly, the ever-increasing capability of medical science and technology, and the need to deal with backlog maintenance on the hospital estate. As plans were put forward for restructuring hospital services, a huge upswell of public feeling gathered against the removal of 'local' services. There was uproar at the proposals to downgrade services at Withybush Hospital in Haverfordwest, with doctors joining local protesters and warning of threats to patient's lives. Many of these small hospitals, such as those in Llandidloes, Builth Wells and Blaenau Ffestiniog, were small cottage hospitals which predated the NHS. There was a strong sense of local ownership and community involvement. A thousand people paraded in Llandudno to oppose plans to remove some services from their local hospital. Across Wales people took to the streets to protest against hospital closures and reconfiguration plans. Against the background of Assembly elections in May 2007, hospital closures became a burning political issue. In April 2007, the Tories in Wales launched an election slogan entitled 'Stop the NHS Cuts'.[44] Plaid Cymru also took up the battle against hospital closures and in the new Aberconwy seat Gareth Jones stood as the 'Plaid Cymru – Save Llandudno

Hospital' candidate. Finally, the Labour Party itself agreed to abandon the plans and to start again, this time with more meaningful public consultation. Rhodri Morgan promised that a future Labour administration would be a 'listening government'.

The faltering progress of the Designed for Life agenda was a blow to Labour hopes for a reformed health service. Significant progress had been made in reducing hospital waiting times. There had been considerable additional expenditure on health, but there were many underlying pressures on resources. Much of the increased expenditure on the NHS has gone on meeting increased costs of staff salaries and pensions. Health trusts in Wales have been squeezed to fulfil obligations placed on them by central government. The cost of new GP contracts and the Agenda for Change scheme to attract more nurses into the profession added to the financial pressures. The gathering sense of crisis about Welsh health services played a leading role in the 2007 elections, and the collapse of Labour's working majority.

Whilst Welsh Labour rejected PFI as a breach of a 'Welsh way', local closures could themselves be seen as departing from a Welsh concern for community provision within, by and for those local areas. At the same time, health needs in rural Wales are complex and addressing them is challenging: preserving what exists is not necessarily the best way to provide expert specialist services and to provide equality. Following its failure to achieve a majority in the 2007 Assembly elections, Labour has been obliged to withdraw its reforming programme and must look to address a mounting health crisis by other means. Whilst people support local services because it keeps the NHS humane and local, the result can be greater expenditure on buildings and bureaucracies than on services. And as Rhodri Morgan indicated when abandoning local closures, the strength of popular and potentially selfish opinion can challenge both the integrated and planned nature of a collective service. Indeed, unless tackled, the mounting financial problems faced by a country with significant health problems will lead to even more serious inequalities between health care in Wales and other parts of the UK.

2007 and beyond

Following the election, the opposition parties sought to build an agreement around some shared values. The terms presented for collaboration in a so-called 'Rainbow Coalition' were set out in a document termed 'The All-Wales Accord'. This outlined areas of common ground in an attempt to "create a more consensus-based politics, free from the tribalism of the old Westminster system".[45] In the area of health and wellbeing the concord promised to address the "crisis in the ambulance and NHS dentistry services and the collapse in public confidence following Labour's badly handled reconfiguration process". Instead, it determined to "announce an immediate moratorium on hospital

closures and proposals to downgrade services", and agreed not to put forward any further plans for reconfiguration until "after fully costed plans on community NHS provision have been presented".[46] It formulated a range of other commitments, promising to prioritise preventative health services, upgrade sexual health services and seek devolution of powers over mental health. However, the plans for a 'Rainbow' administration faltered in May 2007 when the Liberal Democrats voted against the proposals.

Yet it is unclear whether a populist defence of localism, and policy based on a very general sense of shared values produced by very different political parties, would have any real substance. In the 1997 referendum, the Conservative party as a whole hardly embraced 'Welsh' collectivist values or the principle of devolution. Under Rod Richards and William Hague, the Conservatives emphasised 'Britishness', and gave the Welsh party little chance to develop its own stance.[47] Some, like David Melding, have since supported both a stronger devolutionary settlement and departures from the national party line.[48] But the Welsh party's Standing Committee on Public Services has still argued that a mixed economy of provision should be the party's aim.[49] Even if this new enthusiasm for a 'Welsh' and more collectivist way is real, how far would the party's new Welsh (semi-) independence allow it to develop policies which differed from London's? And how far could the Liberals' commitment to choice and individual freedom stretch so that it became compatible with Welsh (collectivist) provision? If values are measured by actions, we cannot tell; but we should at least recognise that a 'Rainbow' coalition would be pulled in competing directions.

A minority Labour administration was formed by Rhodri Morgan in June 2007. Brian Gibbons was transferred from health and replaced by Edwina Hart, an experienced cabinet member. She immediately announced a rethink of controversial hospital plans, and awarded a pay rise to nurses, overturning Gibbons' previous policy. A coalition with Plaid Cymru was considered, based on agreed principles. This included reviewing the plans for NHS reconfiguration, and an agreement not to make changes to existing District General Hospital services until the new community services are in place. Labour and Plaid, in the agreement, also agreed on shared core values with regard to public ownership: "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."[50] Therefore both parties seem to be standing on a shared commitment to 'Welsh NHS values'. They also agreed to seek further powers for the Welsh Assembly and to call for separate mental health legislation for Wales. This may be a road map for the future. However, as the lack of progress on the Designed for Life programme has shown, and as Mark Drakeford pointed out in his incisive review of health policy in Wales in 2006, *making* policy, even with new and radical approaches, is relatively easy – *implementing* the ideas is something else.[51]

Conclusion

The existence of shared values can have a positive role in policy development. The perceived existence of such values can be effective constraints on what politicians contemplate. Public discussion of the need for policy based on values reminds politicians that their actions must appear to be based on principles. Welsh communitarian values have also provided a policy elite with ways of perceiving policy options. The values of many health service professionals reveal a strong commitment to public service and free, community-based, services. The Welsh system has thus been based on shared ideals. However, it is now under considerable strain. Higher levels of chronic illness and deprivation in Wales, global developments, EU policy directives, UK-wide salary scales and the demand for new drugs creates considerable pressures. Calls for services which are comparable in quality to those operating across the border reinforces this problem.

In meeting pressures, traditional values may be modernised and delivered through new methods. The NHS was not founded on a single principle, and it is possible to find multiple traditions and currents which new approaches may revive. Shared Welsh values could help the formation of Welsh coalition governments. However, values shared with British governments could help ensure support for addressing health inequalities within Wales through new funding arrangements. Labour's long domination of Welsh politics and Welsh health policy creates a further problem: we cannot yet see how effective values will be in a new political world where Labour is less influential.

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5. "NOTHING ABOUT ME, WITHOUT ME": NHS VALUES PAST AND FUTURE IN NORTHERN IRELAND

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Northern Ireland is different. It has experienced a turbulent history, its population is relatively rural, it has a small population of only 1.7 million and it has always had higher than average levels of poverty. Separation from the mainland by the Irish Sea has led to relative isolation from the centre of administration, 'across the water' at Whitehall. Direct rule and proximity to Dublin further shape its approach to health. And the result is that the health and social services of Northern Ireland are distinctive, with some distinctive values. The health service in Northern Ireland, as elsewhere in the UK, is regarded as a cherished institution. Not only is it a provider of necessary services, it is also the major employer within an economy which has seen much recession in recent years. It has a stable and cohesive workforce which, in rural communities, often means brothers and sisters providing a service to other family members and close neighbours. In such an environment it is important that the values inherent in the health service reflect the values of society. Rurality often gives rise to parochialism and closed communities, so that the values of the service may also need to reflect local idiosyncrasies if they are to be truly acceptable in every community.

In any public discussion of health service values in Northern Ireland there would be a strong affirmation of the principles on which the NHS was first established – equity, solidarity and universalism. Whilst 'Britishness' is a source of great division across the two communities within Northern Ireland, there is no voiced desire to move away from what might be construed as a uniquely British model. That is not to say that there has been a wholesale acceptance of the policies and practices of the NHS as evidenced elsewhere in the United Kingdom. Many of these policies look from Northern Ireland as if they had been developed and implemented to match the needs of Westminster politicians and the particular problems of the great Metropolis. It has become increasingly clear that the direction being taken by the UK government to health service issues may not match the values or aspirations of the people of Northern Ireland. Devolution, even though problematic, has brought the welcome opportunity to be free from the crushing centralism of Westminster and to mould health services in a fashion which reflects the values and principles of Northern Irish society.

In spite of the hesitancy of the political steps towards devolution, society in Northern Ireland is revelling in the new-found peace. In this post-conflict era there has been a re-awakening of the resourcefulness, industriousness and independence of spirit that has characterised it since its inception. Across the public and private sectors people are beginning again to take affirmative steps into this brave new world. There is energy in society to take ownership of the future. The 'Troubles' have left a mark, a stain, particularly on the thousands of victims left in its aftermath. But it has to be said that this legacy too, has begun to shape and strengthen the values of society and has fostered the demand to see those values reflected in the health service.

So solidarity, equity and universalism remain at the core of the Northern Ireland value system, but they are being reclassified and reinterpreted to match the perceived needs of the modern-day health service of Northern Ireland. The most strongly-held value perhaps, can be expressed by the words "Nothing about me, without me". People want to feel they have had their say, whether at individual, community or regional level. They want to know they have been listened to by policymakers. Public engagement, shared ownership of decisions and the power of the consumer are now indelibly imprinted on the processes by which policies are developed or implemented. Equity is a major objective, particularly recognising that in those communities where there is least advantage, sectarianism can blight progress. There is also an increasing awareness of the need to celebrate diversity and ensure that health services provide for the needs of everyone.

The still-fresh memories of the terrorist atrocities of the past 30 years have placed a high value on localism. The emotional dependence on local acute hospitals will remain for some time to come; the earnest exhortations to rationalise hold no sway in these local

communities. The public in Northern Ireland feels greatly indebted to the health service. Values are strongly held, opinions are forcefully given. Devolution across the United Kingdom presents a welcome opportunity to continue to develop a health service which is in tune with those values.

Historical context

The 'Troubles' have had a significant effect on the delivery of health and social services. Each hospital across the whole of the Province has its own story of responding to the carnage of bombs and bullets, dealing with tragedies such as the Remembrance Day bombing in Enniskillen, Bloody Sunday in Londonderry and Black Friday in Belfast.

One such example comes out of the dramatic and horrific events in Omagh one Saturday afternoon in August 1998. There are many terrible images from that day: dozens of the walking wounded wending their way to Omagh hospital on foot, in taxis and buses commandeered to ferry the seriously injured to the hospital, and military helicopters redeployed to assist in the transportation to other hospitals including the Regional Centres. Across Northern Ireland, dozens of health care workers threw aside their Saturday afternoon activities, got into their cars and drove to Omagh to give professional assistance to their colleagues in the fight to save lives.

Events such as this have shown and entrenched the core values of the HPSS (Health and Personal Social Services) in Northern Ireland. Solidarity and equity on the ground mean providing access to all, free at the point of need, regardless of ability to pay and delivered by well-trained highly committed professionals. There was an unwavering commitment to these values as health and social service professionals dealt with the thousands of people who were physically injured and psychologically scarred by the many atrocities which occurred over a period of more than 30 years. Throughout those years, there was little recognition of the need to equip staff to deal with their own feelings about the civil conflict, nor was there an acknowledgement of the need to address the inevitable psychological scars which resulted. The response of the HPSS to the Troubles has been analysed carefully and eloquently elsewhere.[1]

The emergency responses required so often during those long years of the Troubles have inevitably led to a high level of community dependency on the local hospital. Any perceived reduction in the level of care delivered at local hospitals has been exploited shamelessly by vested interests, with the cry that "people will be dying on the streets". Many of the concerns are not just about medical care. The health service is not just a provider of services it is also a major employer. Northern Ireland was established on a strong economic base reliant upon shipbuilding, textiles and farming. As these industries declined, and repeated attempts to replace them with technology-driven employment

failed, the health service has become the single largest employer in Northern Ireland. It has provided security and, in some places, is the only economic support for local communities.

The changing political landscape

The Government of Ireland Act 1920 led to the establishment in 1921 of a separate parliament and administration in Belfast. Although the Act extended powers to the devolved parliament to "make laws for peace, order and good government", Westminster retained ultimate sovereignty in the crucial areas of finance, defence and foreign affairs. Under these constitutional arrangements the Stormont Government had full devolved authority to determine welfare policies such as health, education and housing.

Following the Second World War the Unionist-dominated Stormont Government viewed, with some distaste, the emerging welfare policies which were being formulated in Westminster. The economy of Northern Ireland at that time was dominated by small-scale agriculture and medium-sized family firms: a strong individualist culture at variance with the implied centralised government and state intervention of the welfare proposals. There was also a fear that implementation of the welfare proposals would lead to a large influx of 'southerners' from the Republic of Ireland and this might bring an end to the ethnic dominance of protestants.[2] Further resistance to welfare reform came from the Catholic Church, which feared the proposals would undermine the role of church and family. And as with the rest of the United Kingdom, the medical hierarchy fiercely resisted the NHS, fearing a loss of clinical freedom and autonomy.

Two factors persuaded the Stormont Government that they had no option but to replicate Westminster welfare legislation. The 1945 election in Northern Ireland, fought on a strong anti-socialist platform, saw a significant defection of working-class protestants to left-of-centre parties. A second decisive factor was the guarantee of subsidy by Britain to ensure the parity principle applied to welfare benefits across the United Kingdom.[3] Despite continuing opposition, 1948 saw the introduction of a health service in Northern Ireland similar in most respects to the National Health Service across the rest of the United Kingdom. The essential care values of equity, fairness and access to all were inherent in the new legislation, and within a relatively few short years significant benefits were realised, particularly in areas such as maternal and child health and tuberculosis. Such obvious improvements in quality of life quickly dispelled any lingering criticisms of the fledgling nationalised welfare state.

Over the next two decades, the Health Service in Northern Ireland became established, following a similar model to elsewhere in the United Kingdom. Perhaps the most significant departure came following a report in 1970 which resulted in the integration of

the Health Service with Social Services to become Health and Personal Social Services in 1973. This radical change in the administration of services was somewhat overshadowed by the tumultuous political events at Stormont with its suspension by Edward Heath – a Conservative and Unionist Prime Minister – and the imposition of direct rule by Westminster. An ill-thought-out experiment in power-sharing by the Conservative government of Edward Heath in late 1973 led to a concerted campaign against the newly-formed Executive. This culminated in a general strike in May 1974, when the Province came to a standstill. The end result was a prolonged period of direct rule by Westminster which lasted until the Belfast Agreement of 1998 when once again power-sharing was attempted.

Devolution

The new devolved Assembly came to power with limited preparedness and no experience in governing. Any expertise in its members came from a position of permanent opposition rather than involvement in policy formulation. The early signs did not augur well. The negotiations which resulted in the Belfast Agreement meant that the structure of the devolved government in Northern Ireland was designed to induce parties to take office rather than produce responsibility for making policy.[4] Despite some noisy rhetoric about local hospital issues, none of the main parties displayed any interest or knowledge on health service matters in their election manifestos. The Belfast Agreement and the establishment of the devolved Assembly held out the prospect of continuing peace, but everyone recognised that there would be a long and very steep learning curve before the new political masters could begin to make their mark with any confidence on the more mundane, bread-and-butter issues of governing Northern Ireland.

In the run-up to devolution Westminster politicians charged with a Northern Ireland brief had quite understandably focused on securing an agreement and making preparations for the incoming Assembly. Westminster ministers were reluctant to be seen to take forward innovative or assertive policies or legislation. They recognised that any major policy developments should await the arrival of locally elected politicians. This led, in effect, to a major hiatus in the health service with what were regarded as necessary reforms being implemented across the UK, but Northern Ireland being left to drift in a policy vacuum.

Further despair and frustration followed when an Assembly was eventually formed. Ministerial positions were chosen under the d'Hondt formula, a form of proportional representation. None of the major political parties chose health and social services, so this portfolio went, almost by default, to Sinn Féin. It was in fact one of the last seats to be chosen. This sent out a clear signal that local politicians saw little electoral value in residing over health and social services, and probably regarded the brief as something of a

poisoned chalice. Many of the newly elected members of the Assembly (MLAs) were engaged, at local community level, in debates and discussions over the fate of local hospitals. In preparation for government they had been fully briefed by civil servants in the Department of Health and Social Services on the need for an urgent rationalisation of hospital services. As was later to be evident, most politicians recognised that the local hospital issue could help to win or lose votes.

The devolved government in Northern Ireland was constructed in such a way that the very small political parties might gain seats. As a result, there are 108 MLAs for a population of only 1.7 million people, a higher ratio of politicians to public than is seen in either of the other devolved administrations. This has meant, in practice, the potential for local issues and local vested interests to play a major distorting role in the ability of MLAs to take a broader and wider societal view. In addition the sectarianism that plays such a malignant and destructive role in the Northern Ireland political landscape would always be there, as a dark shadow clouding political judgement and honest decision-making.

In March 2001, against this background, the Assembly managed to endorse a comprehensive programme for government which included a number of long-term goals.[5] The vision which underpinned the programme was stated as that of a peaceful, cohesive, inclusive, prosperous, stable and fair society, firmly founded on the "achievement of reconciliation, tolerance and mutual trust, and the protection and vindication of human rights for all". The priorities within the programme included growing as a community, working for a healthier people, investing in education and skills, securing a competitive economy and developing relations across the border with the Republic and across the Irish Sea – or, as it is often put, North and South, East and West. This programme for government was highly aspirational and probably undeliverable but, at least superficially, it provided the semblance of a shared vision. Sadly, the considerable effort which was expended in establishing the Assembly and determining an agreed programme for government did not result in an energetic and decisive vehicle for policy decision-making. The Assembly was crisis-ridden and hesitant from the start, with a damaging period of suspension lasting from February until May 2000. Following the events later to be referred to as 'Stormontgate' with its allegations of an IRA spy ring, the Assembly fell again at midnight on 14 October 2002.

Legacies of devolution 1998 to 2002

Despite the short-lived and tempestuous nature of the devolved Assembly there were a number of legislative and policy matters taken forward which have had a lasting impact on health and the health and social services. In addition, during direct rule ministers

promised to work closely with local elected representatives to progress the delivery of their agreed priorities. This enabled a 'ripple effect' to emanate from the Assembly, allowing its impact to last much longer than devolution itself.

Public engagement

Perhaps the greatest change brought about by devolution was the opening up of public discourse on matters relating to the health service. The combination of 108 MLAs, a Sinn Féin Heath Minister and a cross-party committee on health and social services opened the way for much heckling and disagreement. Local issues on health which had barely registered on any radar, previously, were suddenly the focus of media attention and were milked for every possible sensational headline. The problem surrounding local hospitals was seen as a nettle which had to be grasped and was promptly placed in the very capable hands of Dr Maurice Hayes, a former Permanent Secretary of the Department of Health and Social Services. Dr Hayes began a process of wide public consultation with a strong supporting cast of experts. This exercise, and in particular, the manner in which it was conducted, did much to instil a wider understanding of the complexity of delivering acute services and has since eased the way towards rationalising these services.[6]

Whilst many realised the need for change, a bitter dispute ensued between the people of Omagh and Enniskillen over which hospital should retain acute services; the values of localism and local facilities, which have even greater weight in Northern Ireland than elsewhere, make rationalisation particularly hard. The dispute generated so much interest that it became a major electoral issue, ushering into prominence a local general practitioner on a 'Keep Our Hospital Open' ticket. In some ways it was a small sign of progress that people were going to the polls without the usual sectarian slogans ringing in their ears. They had instead, scare-mongering and half-truths about health matters to consider.

Equality

Against this background of political point-scoring on health affairs, public debate was further increased and became more formalised with the implementation of Section 75 of the Northern Ireland Act 1998. The aim of this legislation was to reduce inequalities and to create social solidarity. It required all public bodies, in carrying out their functions, to have 'due regard' to provide equality of opportunity and to promote good relations between persons of different political opinions and race groups. At the heart of these arrangements was the requirement that effective consultation should be undertaken at all stages with relevant community and voluntary groups. The effectiveness of this consultation represents the main way in which a decision could be challenged in the

courts. The legislation includes not only equality on the grounds of gender, race and disability, as in the rest of the European Union, but also includes religion, political opinion, age, sexual orientation, marital status and dependency.

Section 75 has led to a greatly increased bureaucracy in the policy-making process and is regarded by many as poor legislation which is failing those it is meant to protect. It has certainly opened the way for numerous challenges through the courts, questioning the effectiveness of various consultation processes. One of the most highly publicised and bitterly contested examples of this was the challenge to the Health Minister's decision regarding the site of a new maternity hospital in Belfast. The question was whether this new facility should be at the Belfast City Hospital, in predominantly protestant South Belfast, or at the Royal Victoria Hospital on the predominantly Catholic Falls Road. A venomous debate took place at the Health Committee, on the Assembly floor and across the media. Perhaps for the first time in the history of Northern Ireland, debate on a health service matter was conducted openly along sectarian lines. Health service professionals were appalled at the grotesque implications of dragging sectarian rhetoric into a health service which was there to serve all who were in need, irrespective of creed or colour.

The new public health

Despite the partisan and sectarian nature of the politics, the Assembly succeeded in agreeing a major cross-governmental policy initiative which was welcomed by all political parties. *Investing for Health*, an over-arching, comprehensive strategy to promote population health and well-being, and to reduce health inequality, was launched in 2002.[7] Prior to devolution there had been a growing emphasis on partnership for health across government departments, agencies, and the community and voluntary sectors. The Executive Programme for Government heralded the importance of promoting health and had paved the way for intersectoral partnership as a means of tackling inequalities in health. A cross-departmental steering group under the chairmanship of the Health Minister provided a formal mechanism for signing the strategy, but the inspiration and energy for the development of the strategy came from a small multidisciplinary team drawn from the Department and from a network of community development professionals, all with a deep commitment to addressing wider health issues. The strategy was developed using innovative measures to engage broad sections of society, but with a particular focus on reaching disadvantaged communities. The process included a wide-ranging debate on values, with strong endorsement of principles which reflect the rights-based thinking of a society emerging from conflict.

Investing for Health was later to be described by Sir Donald Acheson as the greatest public health strategy written in the English language that he had seen. The proof of its

excellence can be seen in the fact that even four years later it is still very much alive and working. It has provided a step change in the priority given to population health and well-being across government and right through the public sector. It has capitalised on the vibrant community development initiatives which were already in place throughout Northern Ireland. It has been the focus of much community and individual engagement on health issues. *Investing for Health* was perhaps the most successful attempt to achieve a joined-up approach to government. The stated goal of improving health as a priority, forced an agreement on the strategy, which might otherwise have proved difficult, if not impossible, in a political structure where ministers were under no effective obligation to support each other, or to pursue agreed policies. The strategy not only paved the way for an empowerment of individuals and communities, it also led to a strengthening of the role of commissioners in purchasing health as distinct from health services. The four Health and Social Services Boards enthusiastically took on the role of leadership in local and cross-sectoral partnerships set up under the umbrella of Investing for Health. A whole raft of innovative community-based services has been put in place. Recent reports show that the enthusiasm and commitment has been maintained, with many of the strategic goals set on target to be realised.

Post-devolution

The fall of the devolved Assembly in 2002 brought another prolonged period of direct rule. Westminster ministers were understandably reluctant to take forward new policies or programmes apart from those that had been well signposted by the Assembly. This only served to deepen the frustration felt by many at the inability to move forward with much-needed policy and structural reform.

Whilst there was some astonishment at the speed of reforms in England, there was also some considerable envy within the health service in Northern Ireland of the forward direction of travel. It was, in fact, envy of motion in any direction at all. By 2005, when it was evident that there would not be any early return of the Assembly, the policy momentum began to pick up on a reform and modernisation agenda and plans for structural reform began to be laid. Perhaps the most beneficial policy decision to be taken during 2005 was the decision to bring forward legislation to ban smoking in public places. There was a strong and successful lobby from the cancer charities and from within the health service, but the ban was also supported strongly by almost all the MLAs. Direct Rule ministers agreed to this legislation well in advance of a similar line being taken in Westminster. This move was warmly welcomed by most and was seen as a positive step towards strong and effective political leadership from the Direct Rule team.

The impact on values in the HPSS

Has the on–off devolution and the unstable political environment had an impact on the values of Northern Ireland's health service? In the absence of major policy decision-making by politicians the culture and values of the HPSS have remained relatively steadfast and intact. But beneath the surface, subtle change has been taking place, gradually beginning to mould and shape the way in which the health service is regarded, both by those who deliver the service and those to whom it is delivered. These subtle changes have in a small measure been due to the consequences of devolution. But other greater forces have been at play, which have brought inevitable change.

The values of the NHS are different when viewed at the level of the individual, the community or the societal level. The principles, standards or qualities that we expect from the service as individuals or as a community can cut across the ideal of fairness and equity when viewed at a societal level. The belief is prevalent that the health service should make available to each individual every latest new discovery, no matter how costly or how slim the evidence. Each community expects comprehensive acute hospital services on their doorstep, irrespective of how that might prejudice the delivery of high-quality services to a wider population.

In small jurisdictions where political power lies close to the electorate, the pressure on politicians to deliver to local or individual interests becomes a major distorting factor. In Northern Ireland, where devolution brought about a relatively top-heavy political structure, individual or local clientelistic, pork-barrel politics was potentially a very negative factor in decision-making. Dr Garrett Fitzgerald, former Prime Minister of the Irish Republic, has remarked that every politician faces a permanent series of moral dilemmas between serving public interest and acting in a manner which will preserve the support of many of their voters; reconciling these two opposing demands is effectively what politics represents.[8] In a return to power of a devolved Assembly there needs to be an assurance that party or political interests do not contaminate decision-making in the health service. In this way, the public can be assured that the long-held value of fairness and equity in the health service will be maintained. Open and honest debate will also be needed to bring this about, along with a rigorous mechanism for scrutinising the policies and a limitation of the powers of ministers. All major decisions should be dependent on a vote reached on the floor of the Assembly, which would increase public confidence.

It is clear that there are difficulties inherent in having so many politicians engaged in the Assembly. But one advantage has been in the opportunity provided for local or individual views to be expressed publicly. There was often a sense of detachment under the Direct Rule process, a belief that decisions were taken at a remote level from the individual or

community. It was perceived that no local voice would be heard or acted upon. Devolution brought a sea-change. A huge awakening occurred, aided not just by local politicians, but also by voluntary groups, community groups, the media and patient lobby groups. As a consequence of this, lines of communication have been opened up. Today there is much more public debate and scrutiny of the health service. It has undoubtedly led to greater public involvement and a growing confidence that by making one's voice heard it will be taken into account. As a result, there is now a new-found public ownership of decisions, along with recognition that these decisions must address the needs of a coalition of stakeholders. The Northern Ireland branches of the British Medical Association (BMA) and the Royal College of Nursing (RCN) were amongst those stakeholders who became effective lobbyists during devolution. The BMA General Practice Committee was so effective that it successfully lobbied for the retention of GP fund-holding long after it had been abandoned elsewhere. The Assembly may well have recognised the vested interest of that lobby group in retaining a structure that had served them admirably, but it also suited those Assembly members whose only aim might have been to play party politics.

Apart from the BMA and the RCN, there was no strong collective voice from other professional groups. After devolution the Royal College of Physicians, London, along with the General Medical Council, began to establish local bases in Belfast. The medical profession in Northern Ireland has allegiances across colleges in Dublin, London, Glasgow and Edinburgh. Several attempts were made to establish an Academy of Royal Colleges which would act as a collegiate voice to the Assembly, but to date this has failed to materialise. A strong, independent collective medical voice would bring a significant contribution to effective policy-making in the Northern Ireland health service. It could provide a mechanism for growing and nurturing medical leadership.

Core values and social change

Devolution may have nudged up against the values and ideals of the NHS but its impact has been minimal when set against the rather more vigorous assault of other national and global factors.

Public expectations

Whilst devolution in Scotland, Wales and Northern Ireland brought with it the opportunity for divergence, it is clear that many regard parity in access to health services across the UK to be an important aspiration. This manifests itself particularly when it is perceived that patients in any other part of the UK are getting a better deal, notably, with access to new drugs or with variations in waiting times for treatment. Immense pressure is brought to bear on health ministers across the UK if there are differences in priorities and certain patient

groups are seen to fare better in one jurisdiction over another. In certain cases ministers may be forced into decisions which run counter to local spending policies. In England, 'choice' has been given a starring role in the list of core values in the NHS. The case for choice does not need to be argued as we have come to expect choice in goods and services in this consumerist age. What is not clear is whether this is as a result of political mantra, public demand or as a tool to drive market reforms. Within the Health Service in Northern Ireland, choice has not yet assumed such primacy. It could be argued that with the short travel distances involved in Northern Ireland, and the relatively high number of hospitals, choice already exists and is exercised by patients requiring elective hospital care. It could also be argued that the threat of hospital closures has re-awakened long-held loyalties to the local hospital and silenced any calls for the freedom to choose to go elsewhere.

There has been little demand for the option to choose between alternative providers. There has been little demand either, for diversity in the way services have been provided. Consultations on delivery of maternity services in recent years have not uncovered significant demand for home deliveries or for midwife-only care. In part this may be due to failures in the consultation process in that the consultant-led model is still regarded as the gold standard. It may well be that as 'choice' gains primacy as a core value in the NHS in England, the demand for choice may grow in Northern Ireland. The prevailing clamour, at the moment, is not that of 'having a choice', rather it is that of 'having a say'.

"The prevailing clamour is of 'having a say' rather than 'having a choice' "

Doctors and the public

An enduring core value of the NHS has been its professionalism. The public trust in the medical profession remains very high, even in this post-Shipman era and considering the continuing debate about the profession's ability to regulate itself. Within Northern Ireland the medical profession can take some comfort from the successive polls that show that the public trusts and appreciates the medical profession more than it does journalists, lawyers and politicians. In striking contrast, a recent survey showed that the trust people in Northern Ireland have in politicians is at a lower level than anywhere else in the UK. The adverse publicity which surrounded Wakefield's flawed argument on the safety of MMR vaccine severely dented confidence in the vaccine in England. In Northern Ireland, however, immunisation rates remained high in spite of inaccurate media reports, with parents asserting confidence in their general practitioner as a deciding factor. Such trust cannot be taken for granted, as was shown in the aftermath of the Alder Hey scandal over organ retention that erupted in 2001. Doctors watched with astonishment as the media in

Northern Ireland reported the spectacle of the graves of little children being re-opened, sometimes on several occasions, for the interment of microscopic samples of tissue.

Onora O'Neill, in her BBC Reith Lecture 'A Question of Trust' said: "If we want a culture of public service, professionals and public servants, they must, in the end, be free to serve the public, rather than their paymasters."[9] Pay has always been a vexed issue and repeated efforts have been made to try to use pay as an incentive to ensure the delivery of political aspirations for the NHS. The new Consultant's Contract cannot be judged a success and many doctors believe it to be an unmitigated disaster. Professionalism of course demands that a doctor's responsibilities go beyond a mere contract of employment. Compassion and humanity, core values of the NHS, cannot be bought or easily given a monetary value. If pay is the only incentive, and if one is paid only on the basis of delivering to measurable targets, there is a danger that professionalism, compassion and humanity are lost.

Looking ahead

The political negotiations which resulted in the St Andrews Agreement of 2006 brought back devolved government in Northern Ireland. The HPSS community and the public it serves need to be assured that local politicians will return to power with the strength and confidence to take forward the necessary measures to sustain and modernise health and social services. The years of political wrangling and direct rule have led to a debilitating and inappropriate dependence on policy direction from Westminster. The 'London-centric' focus of recent health policies was never designed to meet the needs of a small region such as Northern Ireland and may be deeply damaging if implemented without due regard to local circumstances. The culture and values of our society must be given primacy of place in determining how to shape health and social services that meet the needs of local people. The basic tenets on which the NHS was built, namely free at the point of need; available to all regardless of ability to pay; delivering high-quality services; these values still form the bedrock of our expectations as a society. What has changed, however, is not the 'what', but rather the 'how'. As individuals, communities, or as a society, we now claim the right to have a say. To put it in other words: "Nothing about me, without me."

Decades of inept and at times destructive political leadership have weakened trust in politicians. The challenge for the new devolved Assembly is to provide the HPSS with strong, visionary leadership. The values of the HPSS have remained steadfast and secure throughout troubled times. The retention of those values has provided a common bond and has helped to displace many of the old divisions in and across our society. The HPSS has also been a focus for civic leadership and community development. The challenge for future political masters and HPSS leadership will be to develop a shared vision for the future and to continue a healing process that provides a way out of the past.

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6. VALUES AND HEALTH POLICY IN THE EUROPEAN UNION

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Interest in values is once again to the fore in health care systems throughout Europe and beyond. And, for once, there is reason to pay attention when debates about values take place on a European scale or in EU institutions. What was once exhortation is now increasingly likely also to be policy, and so the definition of European values matters for those who would uphold national ones.

At the 2004 European Health Forum, Ilona Kickbusch called for common values, principles and objectives for health policy in a changing Europe.[1] She claimed that after a decade of economic debate, there was now a desire to think more critically about the values that drive health action. And she posed the questions that form the subject of this chapter: do European values on health exist? And, if they do, how do they impact on health policy-making at various levels – nationally, regionally and globally? Then, in June 2006, the Council of the European Union (EU) published its conclusions on common values and principles in EU health systems. Beyond the confines of the EU, values formed the theme of the European Health Management Association's (EHMA) 2007 annual conference. Individual countries, notably England, are also exercised about values – their nature, place and importance. Many feel a need to revisit and/or represent these at a time when health systems are undergoing significant changes that impact not only on their structures but also on their culture, ethos and values. Having repeatedly reformed its health services since it came to power in 1997, the New Labour government in the UK is

looking to values to provide the glue or story-line holding together the various changes, many of them hotly contested by professionals and public alike precisely because they directly confront long-held cherished assumptions and beliefs about the National Health Service and its purpose. Indeed, the frenzy of health system change seems to be why values are suddenly high on the policy and management agendas.

New values have been, and are being, introduced in health care. As the organisers of the EHMA conference mentioned above explain: "the introduction of regulated competition in a number of countries has been accompanied by greater discretionary power for health care delivery organisations and a more dominant role for patients". Choice for patients and diversity of provision are now major preoccupations of health systems in Europe and beyond. Market-driven incentives are no longer regarded as taboo or unacceptable by left-of-centre governments. Under the cover of globalisation and the pressing need to remain competitive and still be able to afford public services, the virtual hollowing out of such services ushers forth muted opposition, often largely from the 'usual suspects': the professional associations and trade unions. But since these groups are often regarded as part of the problem rather than the solution, policymakers pay little attention to their arguments. And because the public, understandably, find the whole discussion too technical, it is all too easy to make policy by stealth, with developments largely unnoticed and potential implications ignored.

The concern for many working in health and health care is that the new market/profit/efficiency paradigm is transforming health care in unacceptable ways and making it a business much like any other. In so doing, the original or founding core values in health care – equal access for all citizens, a solidarity-based system, quality standards set by the professional community, and caring and serving as values in themselves – are in danger of being forgotten or ignored. The challenge posed by these developments is to discover if it is possible to combine these different sets of values so that efficiency and high performance on the one hand, and high trust and a caring compassionate ethos on the other, may be reconciled in some way. Uniting behind some overarching values could be the mechanism for reaching such an outcome. Even assuming it would be possible to identify and agree such values, a major difficulty lies in ensuring that values count rather than having them degenerate into a token or symbolic exercise or, worse, a cynical one whereby values, having served their purpose to hoodwink an unsuspecting public, are quickly and quietly discarded if found inconvenient in respect of moving on the real agenda that policymakers have chosen.

How far values should, or do, connect with or drive policy, or are a distraction from what is really driving policy, concealing issues to do with power and politics around where health systems across Europe are heading, is perhaps the most important question to

explore. The widespread perception is that there is a serious disconnect between values, policy and practice. While articulating values at one level – for example, the European social model can easily be achieved – it may not be especially useful if it is seen to be contradicted by reality and what happens in practice. Kickbusch cites the example of Canada where an analysis of values in health policy was undertaken. The researchers concluded that while most stakeholders agree that values drive policy goals, decision-making and conduct, they disagree on which values matter most.[2] Moreover, there was lack of shared understanding over what values stand for or are. Values can mean or embrace many things, including the health system, health states, equity, access, economic viability and many different kinds of relationships.

In any discourse on values and health, therefore, Rudolf Klein's assertion in chapter 2 of this book that "the language of values does not translate directly into the language of policymaking, as distinct from policy justification" is surely correct. He goes on to conclude: "values do not drive policy but are revealed in the process of making policy". Such a view underpins this chapter, although it makes it especially difficult to gauge the significance of values in the context of EU health policy and health systems developments. Values abound in discussions about European health policy but their precise contribution to actions and outcomes is far from clear. Indeed, as Kickbusch has noted, values at a European level, if not at a member state level, 'are ambiguous and complicated' partly as a result of their inherent complexity but also because of changing assumptions about the nature of health policy.[3] An example is the introduction of market-style mechanisms as an expression of more pervasive neo-liberal values in society. How these square with long-held values testifying to the importance of what are deemed to be public goods, like health, is not clear although it may be, as later sections suggest, that reaching some accommodation between these seeming inconsistencies is the principal challenge facing policymakers and the public alike in the various EU countries. However, whether such a reconciliation can succeed in a meaningful, as opposed to a rhetorical, way is less certain when there is widespread disillusionment with politics and the political process in many of these countries both at national and European levels.

Relevant to such considerations are related issues such as whose values are dominant and how do these get articulated? Then there is the question of what Europe itself is and stands for. Is it a monolithic leviathan or much less joined up and more diverse? Is it a Europe of nation states or a Europe of regions? Such questions have become more acute and at the same time less easy to answer in an enlarged Europe that has changed the face of Europe in dramatic ways. Certainly, whatever enthusiasm there was for the European project has largely become dissipated in recent years in the aftermath of voting for the intergovernmental constitution. While much of 'new' Europe voted in favour of the constitution because they joined Europe in a spirit of great hope and optimism, countries

making up 'old' Europe were far less committed to the European ideal as expressed through its current institutions. Fairly or unfairly, these were perceived as being elitist, remote, unaccountable and possibly corrupt following some celebrated audit malpractices.

Health system values in the European Union: do they exist and what are they?

A prerequisite for considering values and health policy in the EU is to ascertain whether there exist identifiable European values and beliefs. Many observers believe such values and beliefs do exist. Martin McKee, for example, notes the particular emphasis on inclusiveness and social solidarity as representing the essence of the European social model.[4] Indeed, the term 'European' is often used in debate to signal concerns for equity, social fairness and solidarity. Will Hutton claims that the European view is of a vigorous public realm, fundamental to the good society and characterised by a belief in the social contract, in just capitalism, equity and qualified property rights.[5] The USA, with its emphasis on individual freedom and the safeguards of the market, he describes as Europe's 'other'.

However, McKee is careful to state that though distinctive values may be identified this does not mean there is a single European perspective. Rather, there is great diversity evident across the different countries and health care systems that go to make up the EU, albeit within certain generally agreed boundaries. This applies especially since the enlargement of the EU with the arrival of the accession countries in the last few years. The rich diversity evident across Europe has its origins in each country's political, economic, social and cultural inheritance. While the concept of 'European values' remains useful and important, McKee suggests that it refers not to an exclusive geopolitical culture but to a commonly shared historical culture, a long tradition of European thought about health and its function in the public arena. Adherence to a notion of the European social model that remains only sketchily articulated and understood does not prevent other values gaining ascendancy in Europe, notably what Philip Bobbitt in his epic book, *The Shield of Achilles*, refers to as the transition of welfare states to market states as the coming world order.[6] Within a health policy context, the 'modernised' NHS in England may be viewed as an example of this shift underway.[7]

The important thing to understand about the EU is that it is primarily concerned with economic matters and the building of a common market. The drive for a single market governs everything that matters in the EU and lies at the heart of its genesis and very being. Social policy, including health, is not uppermost in policymakers' minds. A good example of this was the attempt to include health care services in the European Commission's proposal for a Directive on services in the internal market. After much criticism from the Parliament, health care services have been removed from the scope of the Directive on the grounds that

health ministers "strongly believe that developments in this area should result from political consensus, and not solely from case law".[8] The concern over the Directive led to the 25 health ministers of the EU endorsing a statement on common values and principles that underpin Europe's health systems. These values are intended to be referred to and respected when specific proposals concerning health services are being put forward. The Statement makes clear that the subsidiarity principle should remain uppermost in respect of how the common values and principles in health systems become a reality in the various health systems. In particular, they will vary significantly and will continue to do so. In an important passage, health ministers state:

> *In particular, decisions about the basket of healthcare to which citizens are entitled and the mechanisms used to finance and deliver that healthcare, such as the extent to which it is appropriate to rely on market mechanisms and competitive pressures to manage health systems* ***must be taken in the national context.***
>
> (p. 4, emphasis added)

So what are these common values and principles which the health ministers wish to emphasise and ensure are respected? And can they really be expected to be of equal significance across such a range of diverse health systems? The values appear to centre on four dimensions:

- universality – no one is barred access to health care
- access to good quality care
- equity – relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay
- solidarity – is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all.

In addition, mention is made of reducing the gap in health inequalities, and the work of member states on the prevention of illness and the promotion of healthy lifestyles. These "overarching values", it is asserted, "have been widely accepted in the work of the different EU institutions" and together "constitute a set of values that are shared across Europe".[9] The health ministers wish to ensure that they are safeguarded in future. However, it is not made clear how such values will be effectively policed and safeguarded.

Towards a health strategy for Europe

The Statement from health ministers reflects earlier thinking by DG SANCO[a] and its former Commissioner, David Byrne, who sought to raise the profile of health policy and

a. Directorate-General for Health and Consumer Protection, the 'department' of the European Commission responsible for health policy.

articulate within a European context the argument advanced earlier in the UK in two influential reports by the government's adviser, Derek Wanless, that health equals good economics.[10] Health and wealth go together. Byrne attempted in 2004 to open up a dialogue along these lines with a view to putting health much more at the centre of Europe in terms of what it stood for and meant to its citizens. He maintained that "modern economic progress has been built on good health – longer, healthier, more productive human lives". For him, "good health is key to economic growth and sustainable development". He also wanted to shift the emphasis from treating ill-health to promoting good health. This requires "a paradigm shift from seeing health expenditure as a cost to seeing effective health policies as an investment".[11] The statement on common values and principles from the health ministers endorses this approach although clearly regards preventive measures as a means of reducing the economic burden on national health care systems. "Prevention significantly contributes to cost reduction in healthcare and therefore to financial sustainability by avoiding disease and therefore follow-up costs."[12]

"Notions of universality, equity and solidarity risk being compromised by an increasing focus on choice, competition and diversity"

Despite the statement and its articulation and endorsement of what it considers to be a distinctive set of European values and principles that should not be violated by markets and competition, the health ministers note on page 7 "increasing interest in the question of the role of market mechanisms (including competitive pressure) in the management of health systems". They acknowledge the many policy developments in this area that are underway in health systems across Europe aimed at encouraging plurality and choice, and making efficient use of resources. The way forward, they insist, must be to learn from the various policy developments in this area while leaving it to individual member states to determine their own approach.

Decoding such language, it suggests that despite the removal of health services from the internal market Directive, the overall direction of travel remains clear. That is, market mechanisms are here to stay in health care with all the risks these pose for the common values and principles set out in the health ministers' Statement. Such potential threats and contradictions are not considered in the statement even though they go the heart of whatever values are supposed to be enshrined in the European ideal when it comes to the public's health. Notions of universality, equity and solidarity surely risk being compromised or undermined with an increasing focus on individual choice, competition, and diversity in provision and perhaps even funding mechanisms. So far countries like the UK have remained wedded to the principle of universal access to health services free at the point of use with a single payment system in operation in the form of central taxation. But there is

nothing sacrosanct about such a principle and many people across all political parties and elsewhere are openly discussing, if not advocating, a system of user charges, co-payments or top-up fees over above the basic minimum basket of services, since in their view raising taxes is not an option.

Following the consultation on Byrne's reflections on a new EU health strategy, the Commission published a discussion document in 2006 which offered stakeholders the opportunity to comment further on plans for an overarching health strategy to be adopted in the summer of 2007. The opening sentence is in keeping with the values expressed in the earlier consultation: "Health is important for individuals and for society."[13] Improving the health of European citizens is regarded as important for the European Union since achieving its goals of "prosperity, solidarity and security requires a population in good health". In relation to solidarity, the issue is one of reducing health inequalities across the enlarged EU in terms of life expectancy, health status and the provision of high-quality health services, all of which will help ensure a more cohesive Europe. The discussion document seeks to clarify where the EU can add value and build upon its health work. While member states have the prime responsibility for deciding on the organisation and delivery of health services and care, a number of health issues with a cross-border or international dimension, such as prevention of pandemics or movement of patients or health professionals, require cooperative action at the EU level. The EU has a particular contribution to make to public health in areas such as tobacco advertising and other areas of health protection.

The document is also aware that both the EU itself and the societies it encompasses have changed significantly. As noted earlier, there is far greater social diversity and economic inequalities as a result of the enlarged Union. Health is therefore an issue almost certain to become more important at a European level. The new strategy has been conceived with this likelihood in mind. Hence its focus on new developments in the areas of health services, health threats and health in all policies. The last of these developments is potentially the most interesting in a European context since it would remove health from being the sole preserve of DG SANCO and would make it an issue for all DGs. The concept of Health in All Policies owes its origins to the Finnish Presidency which ended in December 2006.[14] It requires that all new initiatives at Community level must have an impact assessment which considers what impact the policy will have on other sectors, including health and health systems.

Part of the dilemma lies in the point made earlier, namely, that the EU is essentially an economic idea and construct which drives its various institutions – though possibly not the Parliament, although this is probably the weakest EU institution. But part of the problem may also lie in the whole conception of health and health policy and what they stand for

and/or represent. These are hotly contested concepts. Gill Walt, for example, reflects on a discussion she took part in among policy analysts about the meaning of health policy. For the economist from the World Bank it was about the allocation of scarce resources. For the Ugandan health planner it was about influencing the determinants of health in order to improve public health. For the British physician it was about government policy for the health service.

In the EU, the treaties are concerned with public health rather than with health care systems although much of what happens in the EU beyond its public health interests directly affects health care systems, including the various rulings of the European Court of Justice in respect of people going to other countries for treatment while expecting their own health service, which may have required them to wait or did offer that particular treatment, to pay the costs. Another recent example is the Working Time Directive which brought with it major implications for the health care workforce in member states, and the cost of staffing services and training professionals. But the EU is principally concerned with economic matters. This means that concerns associated with health and health systems tend to remain near the bottom of the agenda except when, as in the case of the internal market Directive mentioned earlier, it is seen as commercially attractive and a source of major economic development with significant market potential. The notion that health systems contribute to social cohesion and social justice is of secondary importance, whatever the rhetoric or values may state. Indeed, such concerns only receive serious attention if couched in terms which can demonstrate their contribution to economic development. In such a discourse, only one value seems to matter and constitutes the bottom line – a thriving European single market. Such a reductionist and economically driven approach may account for why the development of a comprehensive health policy framework has not yet been achieved. It may also account for the lack of a focal point for health policy, with developments affecting health policy, such as the Working Time Directive, emanating from other more powerful directorates within the Commission. Having said this, Robert Madelin, DG for Health and Consumer Protection at the European Commission, suggests the issues are more complex. Delivering a lecture at the Royal College of Physicians in London, he explained that "behind the headlines that say Europe is about markets and competitiveness against social goods or public goods, the same European Council is adopting Healthy Life Years (the sustainable health and wellbeing of individual citizens) as a key performance indicator for its competitiveness agenda".[15] He viewed this as a sign for optimism.

Ilona Kickbusch believes that the lack of serious attention to health policy in most countries affords an opportunity for the EU.[16] The European Commission, through its work on public health, aims to protect and promote the health of European people.

Health is a key priority for the Commission and, given its comparative neglect in most countries, she believes an opportunity exists to develop it in a European context. Indeed, work on public health has been allowed to develop at a European level precisely because member states had rather neglected their public health systems possibly because they were not seen as critical as the curative sector. Member states therefore saw no serious political risk in allowing the Commission to meddle in this undefined area of health to which most did not accord much importance. Their main concern was that the Commission should not interfere with countries' health care systems. Consequently, at an EU level public health policies have been strengthened in recent years. Contributing to this development have been national public health scares around food safety such as BSE and foot and mouth disease, and an acknowledgement that health is a transnational issue. The EU is committed to promoting health and preventing disease through addressing health determinants across all policies and activities.

Despite its growing importance, public health policy remains weak within the EU's overall responsibilities. Indeed, other policies frequently contradict public health policies. A good example is the common agricultural policy with its subsidies for food production and cheap food which may well contribute to poor health in terms of rising obesity among European countries. More generally, in the enlarged Europe, there are major inequalities in evidence including marked differences in mortality rates. Why should a Swede live up to 12 years longer than a Lithuanian? Smoking kills, yet some EU members are able to disregard this fact. Why? And why is there a standardised approach in respect of the single internal market yet no such approach when it comes to public health, disease prevention, health protection and promotion? Despite David Byrne's efforts as Commissioner for Health and Consumer Protection, why is health not seen as critical to the future of Europe as being competitive in a global economy? Indeed, similar questions are being asked within EU member states such as the UK in the context of debates about happiness and wellbeing led by, among others, Richard Layard and the New Economics Foundation.[17]

One explanation may lie in the way functions and policy areas are packaged and compartmentalised in the EU, each located in its own self-contained silo rather like the situation prevailing in most countries making up the EU (although Finland made the theme of health being a key aspect of the work of other policy sectors and departments a central feature of its Presidency of the EU). More commonly, health is seen as a narrowly defined organisational and policy sector: the health care system or public health system, and not an especially significant one at that. It is not regarded as a guiding value of European policy-making that goes beyond seeing the EU as a common market to a union that promotes the common good for Europeans. In such a context, health and wellbeing would then play a central rather than a peripheral role and constitute a core value.

However, Robert Madelin argues that important progress is being made in this direction. Looking across the range of EU action, it is possible to identify many areas which demonstrate that Europe is determining the parameters for some of the non-health drivers for health outcomes such as water, food safety and product safety. Moreover, the treaty of Maastricht stipulated that a high level of human health protection should be ensured in the definition and implementation of all Community policies and activities.

Despite the overall lack of attention to health, the EU has enlarged its interest in this field especially in respect of public health and its improvement. In contrast, as noted earlier, health care systems are seen as lying outside the EU's competence and subject to the principle of subsidiarity. The paradox arises, therefore, that while the EU has no well-considered position on health services, it promotes and enacts many policies which affect directly or indirectly the provision of health services in its member states. It is conceivably an unsatisfactory state of affairs since there remains a lack of effective central focus or mechanism for health-related activities. This raises deeper issues about accountability and governance.

It has also been claimed that within the devolved UK context, where England, Wales and Scotland have differentiated health policies, the threat to the distinctive and arguably more collectivist approach seemingly favoured by Wales and Scotland may come under threat not so much from England (despite it having adopted a neoliberal market-based approach) but from Europe, where the push for opening up services to competition and market-style disciplines is becoming ever stronger. This is an issue and set of policy dynamics deserving of more attention, where potentially a conflict of values is evident with different sets of values underpinning these different stances. For instance, despite the rhetoric of a social model lying at the heart of Europe, health policy and its content are arguably increasingly regarded as a form of commodification. There is little connection between health and health inequalities and macroeconomic and trade policy-making despite occasional polemics such as the argument about the services Directive.

Moreover, there is an implied assumption that 'Old Europe' is seeking to hold on to outmoded values and cherished privileges that have no place in the modern world. Marquand is a vociferous critic of the modernisation thesis and its unchallenged assumption that there is only one route to modernity. The current orthodoxy that "the agenda of the dominant players in the global marketplace is, by definition, modern and that the only motive for seeking an alternative is fear of change" is both problematic and contestable.[18] Not unrelated to this assumption is another misconceived assumption, namely that the American model of capitalism is the wave of the future and that all other models either have been, or soon will be, superseded. In his view, this assumption is also contestable. According to Marquand, two 'paradigms of modernity' are in contest. One is

essentially managerial. It is the paradigm of enlightened – or at least successful – corporations. It is about control, assessment, audit, measurement, surveillance. Those who hold it talk the language of teamwork, consultation, even decentralisation. But tasks are set at the top, not negotiated with those at the bottom… in a profound sense, it is a paradigm of distrust. The second paradigm is pluralistic. It values autonomy, creativity and diversity. It is a paradigm of negotiation and mutual learning. Its exponents are instinctively suspicious of central control, and seek checks and balances to restrain central power. For them, change – worthwhile and lasting change, at any rate – comes from the bottom up. The faltering advance of the European project may well have its roots in this clash of cultures and the different values informing each. Certainly Marquand sees the Commission as a good example of the first paradigm.

It seems, rather like many member states in fact, that the EU wants it both ways – economic growth and prosperity in a more competitive global context coupled with good health for all. Achieving an alignment between these goals across Europe has proved problematic for many countries – with the possible exception of Scandinavia – although even here more egalitarian policies and narrower income and other differentials between social groups are under some strain as cost-cutting measures become inevitable. To expect such an alignment to be possible at a European level seems like nice rhetoric but little more.

Values and actions

At the start of this chapter, attention was drawn to Klein's distinction between values as rhetoric on the one hand, and as policy-making on the other. It is a distinction that the Director of the European Region of the World Health Organisation (WHO), Marc Danzon, supports and elaborates upon in an essay on the 'value of values'.[19] He claims that while values are evident in the preamble of almost every national policy and glossy strategy statement, they are less visible in the core texts of these policies, in the parts that describe actions, resources, implementation and evaluation. A serious mismatch exists between, on the one hand, values which are seen as inspirational or aspirational and, on the other hand, the reality of policy-making in health with its trade-offs, compromises and *realpolitik*. As Danzon puts it, values are used as a mantra rather than as an agenda. A similar point is made by McKee when he asserts that while the European project is committed to improving health, "there is still much to be done to take [such policies] beyond the aspirational to a point where they have a significant impact on health".[20]

The symbolic nature of values posed a dilemma for WHO which it had to confront when updating in 2005 its Health for All policy framework[21]. It asked important questions:

- What role do values play in the region's national health sectors?
- What are the values valid for the European health sector in the 21st century?
- Do these values also lie at the heart of policies formulated in other sectors, notably the major policies dealing with national, social and economic development?
- How can these values be better understood; how can they be made more useful to policymakers?
- What kind of mechanisms would contribute to the practical implementation of these values?

In its review and analysis of these questions, WHO discovered that while many member states endorsed the values espoused in Health for All and similar to those noted above and made explicit reference to them in their national strategies, it did not mean that those values were necessarily driving health systems. Upon further investigation, national experiences demonstrated a lack of consistency between stated values and actual practice. For example, while most national health policy statements declare commitment to equity and solidarity – key European values – in practice equity is not progressing and the gaps in health status and health gains between different social sub-groups are increasing. So, what is the value of a value if it seems, well, value-less because the evidence suggests that it is not respected in actions taken (or rather not taken)? In such a context, we might then ask: do we need values at all? What is their purpose? Do they, we might ask, add value?

One might argue that values in health are important in the EU because they are an attempt to provide a counterbalance to what would otherwise be an entity driven entirely by market concerns and competitive principles. This would risk losing sight of the fact that health is not a standard market commodity which can be subject to the rules and disciplines of the single market. As Wanless argued, health is a desirable goal in its own right.[22] It was a view echoed by the former EU Commissioner for Health and Consumer Safety, David Byrne. The core values of equity, solidarity and participation lie at the heart of the European social consensus. But, as argued earlier, these seem to be overshadowed by advocates of the Washington consensus pushing their dominant essentially neo-liberal values at a global level. Admittedly, this neo-liberal consensus is now perhaps less assured than it was and is on the defensive following the unfolding tragedy in Iraq. Nevertheless, notwithstanding David Marquand's attempt to fill the void, there is no clear alternative view of progress and modernity on offer. Until there is and it results in a social movement which would create a tipping point in political discourse, it seems that the notion of the social model in Europe is nothing more than a veneer that means little in action.

Perhaps such a conclusion is overly pessimistic. On the enduring nature of European values in respect of the welfare state, McKee is more optimistic and suggests that the values underpinning the welfare state "appear to be held strongly and while they may fluctuate from time to time they do appear relatively stable".[23] In his view the demise of the welfare

state may be premature. However, McKee was writing some years ago before the enlargement of the EU, and before the marketisation of health policy got under way in earnest in countries like England (though to a far lesser degree in Wales and Scotland post-devolution). It may well be that those anxious to preserve long-standing values and to make them more than mere rhetoric need to confront a new world order. Part of this entails what Bobbitt calls "the death of the society of nation-states".[24] By this he means that, increasingly, nation states are losing their definition and borders are coming to count for less. At the same time, he argues that there is no 'Euro-identity' or other transnational identity evident to fill the vacuum. Instead, "globalisation has undermined the collectivist values represented by the nation-state and turned attention to the benefit of individuals".[25] Faced with such a development, governments of nation states seek to assert national cultural identities against a fragmenting populace. The notion of 'Britishness' advanced by Prime Minister Gordon Brown, however misconceived and meaningless to those living in Britain, is a good example of this attempt to preserve the nation state and breathe new life into it. Whether the so-called 'modernisation' of health services is approved of or not, as Ilona Kickbusch has argued, those active in public health in Europe need to understand and work with the new world of public policy which is increasingly penetrated by markets and notions of choice and consumerism. It is a challenge that for the most part most of those working in public health are singularly ill-equipped to meet. Complicating the issue is the observation by McMichael and Beaglehole in which they acknowledge the tension between the philosophy of neo-liberalism, emphasising the self-interest of market-based economies, and the philosophy of social justice that sees collective responsibility and benefit as the prime social goal. In their view, "the practice of public health, with its underlying community and population perspective, sits more comfortably with the latter philosophy".[26]

A reassessment of the values of those working in public health would therefore seem desirable. Over 15 years ago Julio Frenk (now Health Minister of Mexico), wrote that public health had been one of the vital forces leading to reflection on, and collective action for, health and wellbeing. But for some years now, the impression exists that this leading role has been weakening and that public health, as Frenk puts it, is experiencing "a severe identity crisis" as well as "a crisis of organisation and accomplishment".[27] Returning to some of these concerns more recently, Frenk puts forward four principal values as perhaps representing a set of common values that a modern health system should reflect and reinforce:[28]

- social inclusion and citizenship
- equality of opportunity
- individual and family autonomy and pluralism
- social responsibility and solidarity.

As Frenk observes, the adoption of health policies should proceed from some concept of societal consensus with respect to values, principles and purposes of the type listed above. Policies can then be analysed in terms of their consistency with the preferred ethical framework. In practice, however, health policy and health system reform does not follow this logic but plunges into the defence of programmatic or structural proposals and solutions. This is as true of Europe as elsewhere. A glimmer of light might be discerned in Robert Madelin's optimism and progressive reading of the treaty of Maastricht and the Healthy Life Years objective. He believes the potential exists to try to use non-health policies at the European level not just to make sure they are doing no harm but to try to make them vehicles for leading towards more rapid change in the right direction. Such a direction is also in line with the Finnish government's Health in All Policies initiative which featured in its Presidency of the EU in the second half of 2006 and which was commented on earlier in the context of the forthcoming EU health strategy.

The future of values in European health

Adapting to the emergence of the market state requires, according to Bobbitt, a strong emphasis on the production of public goods. The market will not do so unaided but the absence of public goods will invite revolt. By public goods, he includes qualities of reciprocity and solidarity; these are required domestically and internationally. However, developing these values will occur within a new world order that will not be an extension of the past. For Bobbitt, "we are living in one of those relatively rare periods in which the future is unlikely to be very much like the past". Quite the contrary – we are plunging into a "new age of indeterminacy".[29]

Looking to the future European dialogue on health and the form it might take, Kickbusch suggests that four frames or mindsets can be identified which offer entry points for a new debate about the place of health in Europe.[30] The four overlapping frames or mindsets consider health as:

- an intrinsic value and human right
- fairness and social justice
- an overarching policy goal which addresses social determinants
- a transnational public good.

These frames appear in Frenk's principal values, identified above, and in the dimensions making up the Madrid Framework.[31] Perhaps the Madrid Framework, with its 11 dimensions for values debates, also offers a basis for such a dialogue that is both transparent and explicit:

- health and wellbeing
- equity and fairness
- choice
- democracy
- stewardship
- evidence
- efficiency
- synergy
- sustainability
- interdependency
- creativity.

The dimensions, taken together, enshrine a set of values that have been considered earlier in this chapter and which have their origin in a long European tradition of public health. They are characterised, not surprisingly, by an emphasis on equity and fairness and on the need to mediate between this social fairness and the wish for individual freedom of choice – the hallmark of the market state that, if Bobbitt is to be believed, is progressively replacing the nation state. The precise dimensions and their meanings matter less than that the Madrid Framework, and other frames and mindsets, offer a set of reference points for a European dialogue on health: understanding health as an intrinsic value in itself as well as a human right; seeing it as a basic contribution to fairness and social justice within a European context; ensuring that health is part of a range of policies that address the determinants of health; and relating European health to global developments within which health is recognised as a global public good.

If the notion of the European social model is to have any real meaning and value as well as substance, then the value and place of health within it needs to be clarified and made transparent. But such a discussion also needs to be opened up and to occur with the citizens of Europe and not be confined to heads of state – Marquand's second paradigm of modernity. Only then might the European project, which continues to remain somewhat moribund, be given new life and a renewed sense of purpose. What remains unclear is what will trigger this process – because it is most unlikely to happen of its own volition.

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7. CONCLUSION: WHAT MIGHT WE DO?

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Devolution in the United Kingdom is about difference – political differences in means and ends. Whether we see it in this volume or in casual observation of policy debates, devolution in the UK is often thought to be working 'best' if it produces divergence and separation between the systems. It does not need to be that way; there are other countries that do it differently. Debates in German and Austrian federalism do not focus on the desirability of divergence but rather on the need to maintain and defend standards of welfare provision that are similar across the entire country. But it reflects the distinctive history of the UK. Pre-1998 administrative and post-1998 political devolution were both born out of a Scottish, Welsh and sometime Northern Irish desire to make policy differently. The values entrenched in policy and health services today have deep roots.

We see the emphasis on difference in the UK's institutions. The 'fragile divergence machine' that is the UK devolution settlement combines a structure that permits great policy divergence with very fragile institutions. The Barnett financing formula, or the division of responsibility in health policy areas such as training, the European Union and research, is intricate, insubstantial and could easily be changed without sufficient thought. That could create policy problems; it could interfere with the expression of divergent values around the UK; and it could become a fully fledged constitutional issue if one part of the UK felt its autonomy had been injured.

The essays in this book do reveal strikingly different talk about values and uses of values.

Box 2. Diverging Values in the UK and Europe?

Values are not just about ends; they are also about means. This creates one of the most striking differences between England and the EU, on one side, and the three devolved systems on the other. English policymakers and the EU often focus on ends more than means, and policy debate is about fitting means to ends. Policymakers and the policies revealed in practice in the three devolved systems are all far more concerned with communitarianism and local participation as means and as ends.

England has seen the most turbulence in health policy and health services, and might also see the most turbulence in values. An appeal to values is one way for policymakers to try to make sense of their actions. It is also a useful way to win legitimacy, by proposing that changes such as the promotion of private sector participation are in keeping with subtly redefined values. It is an open question whether the different lists of values articulated, especially by officials integrating *contestability* and *competition* into policy, find much resonance in the NHS itself.

What stands out in **Scotland** is the focus on *collaboration* and *collectivism*. This means not only breaking down divisions left over from the pre-devolution days when competition was an important theme; it also means increasing public participation and efforts to align the health services and their decision-making with popular opinion. One participant also remarked that Scotland has rejected contestability and competition – keywords, as noted above, of English policy.

In **Wales**, *communitarian* values and a commitment to *communication* are important and to a large extent shared by different parties – but are under pressure from the sorts of public health problems that communitarian ideas are often supposed to solve. Welsh policymakers have, like their Scottish counterparts, rejected contestability and competition.

In **Northern Ireland** the legacy of the Troubles has shaped the values of the health services – directly, by creating a commitment to neutrality in a divided society, and indirectly, by creating a commitment to democratic participation after too long under direct rule. The result is the strongly-held value of community participation: "nothing about me, without me" and a commitment to the kinds of new public health that might help to heal a troubled society. Once again, respect for local communities takes precedence over technical arguments about appropriate means to produce health care.

The **European Union's** values, finally, are and will be the products of political debate. They cannot grow out of its health services because there are no EU health services; they can only slowly emerge from policies and from the preferences of increasingly dense networks of professionals and policymakers. That means that the values driving policy now, or invoked in policy debate, are themselves mostly the products (and tactical weapons) of different, contending, political forces.

Challenges to divergent values

The emphasis on divergence gives full rein to the different politics, preferences and values of the four political systems of the UK. The fragility of the institutions, which depend on unspoken understandings that are less and less understood, increases the chances that debates about values will turn into political crises. At the same time, divergence – for better and for worse – cuts across the various forms of European harmonisation that come with regulation, statements of shared values, and EU-wide networks. That means balancing the logic of divergence and the logic of shared values is the task facing all policymakers – indeed anyone who wants to be intellectually coherent. There are three reasons to expect that it will present a challenge.

The first challenge: public opinion, expectation and values

The first reason that peaceful divergence is likely to end is the limited public tolerance for variation. In the UK, the assumption is often that the purpose of devolution is to produce divergence. This assumption is powerful, rooted as it is in histories of this multinational state and the specific experience of Thatcherism that did so much to create support for devolution. But it is by no means shared around the world, or by the UK population. Globally, for every country like the UK or Spain that values divergence there is another, such as Germany or Australia, whose public and policymakers see decentralisation principally as a way to better deliver identical standards. The publics of the UK, when asked, have as little tolerance for divergence in their rights and responsibilities as any Australian or German survey sample.[1] There is very little evidence of a public demand for divergence when we ask general questions in public opinion surveys, in the UK or anywhere else. What this means is that there is a potential tension between the established fact of divergence in health policies, entitlements and outcomes, and public opinion that does not see it as valuable.

"balancing the logic of divergence and the logic of shared values is the task facing all policymakers"

The *Daily Mail*, among other interested parties, already knows how to appeal to this lack of public tolerance for divergence: "MEDICAL APARTHEID", its front page shrilled on 20 October 2006; "Another life-extending drug joins list of medicines given to Scots but denied the English." The article quoted the Conservative health spokesman as saying that "either we have a National Health Service or we don't. In fact it has become a Scottish and a separate English Health Service." That naturally sits poorly with Gordon Brown's speech to a 2006 Labour party conference in Manchester, one of many, asserting that the "reason I

make speeches about my pride in Britain and Britishness is that valuing our shared purpose as a country will be as critical to our success and cohesion in this new century as it was in the last when we together defeated fascism and built the NHS and together in the century before when we led the industrial revolution".[2] Indeed, the Brown government's first major policy statement, on constitutional reform, asserted that "shared values are the bedrock on which the elements of our nation are built. Our values are given shape and meaning by the institutions that people know and trust, from the NHS to Parliament."[3] If the NHS systems do not have strong shared values, this has serious consequences for Britishness.These are dangerous political waters – a Scottish Labour leader makes the case that the NHS is a value of Britishness, while the Conservatives and the *Daily Mail* are all too happy to point out that the NHS is not shared (and is better funded in Scotland).

Nor does it sit well with the current complexion of governments in the UK: an SNP government in Scotland; a Plaid Cymru–Labour coalition in Wales; the DUP and Sinn Féin in Belfast; and a Labour UK government in London. The political thought of Plaid Cymru and the SNP is generally as sophisticated and complex as the political thought of the UK party headquarters in London – and is almost always far more sophisticated than they get credit for in the London press. But they are nationalist parties. They speak of differing nations and national priorities and a reluctance to be subsumed into the UK. The SNP government, in its August 2007 paper on the future of Scotland, adduced better health policy as a reason for greater autonomy or independence.[4] The One Wales agreement that underpins the coalition in Wales calls for a review of the Barnett formula that funds the devolved governments, partly because there are strong arguments that it underfunds Welsh public services.

This often means that they make the strong claim that their publics are more social-democratic than the English – a claim that is barely true. So when we look at public opinion, they are on no thicker ice than is Gordon Brown. And all we know about the politics of countries with longer histories of political decentralisation tells us that claims and counter-claims from the Prime Minister, *Daily Mail* and others, and a mixture of values debate, intergovernmental troublemaking, and sheer political opportunism, will be the future.

But the simple poll questions that find so little appetite for divergence – asking, essentially, if the respondent supports different health standards – hardly plumb the full complexity of health politics and debates (indeed, they make it hard to distinguish the UK from most other countries and their publics). That is because politics, policy debates, personalities, history and practical problems mean that values can and do get traded off. Some are more important than others. Furthermore, policies influence the meaning of values, so that a commitment to the autonomy of patients means very different things to English policymakers working on choice, Scottish or Welsh policymakers working on

service integration, or European Court of Justice judges deciding on the extent to which patients in the EU enjoy cross-border patient mobility.

The inability of simple public opinion questions to reflect the divergent policy decisions, histories and conversations of each country is why articulating the values in health policies is important. People might be willing to extend rights to short waiting times, public provision or expensive drugs far beyond the place they live, but the way they talk about values and the way issues emerge are very different. This shows in the very different assumptions and languages captured in the different essays and seminars. What are the values expressed in the health and political systems? How do they justify and put moral grounding under the decisions made over time? Such values, if articulated, might capture the justification for divergence – and reveal areas in which there is no good democratic case for divergence. They are used to justify difference every day, but if not explained might be trumped by jealousy and talk of postcode lotteries (or worse, given that state and stateless nationalisms can easily be invoked, and easily turn ugly).

The second challenge: intergovernmental conflict and values

The UK has enjoyed a remarkable honeymoon in intergovernmental relations, attributable largely to the fact that the Labour party has been in government across Great Britain. This underpinned coordination, accommodation and a culture of 'no surprises' in intergovernmental relations, aided by a unified home civil service that preserved networks across England, Scotland and Wales. There was never any evidence that this situation would last and May 2007's elections ended any pretence that it could. Intergovernmental conflict will become a major feature of politics in the United Kingdom, just as they are in all other decentralised states. Now, governments have incentives to pick fights. These fights use values – and turn them into policy decisions that would not otherwise be made. In Spain, Socialist Andalucia paid for medicines that the rightist Spanish government did not want to provide, and embarrassed Madrid into paying for them. In Canada, with the Canada Health Act the federal government declared itself the moral and financial guardian of the Canadian health system and the values attached to it. This was possibly a good thing, but one that disregarded the autonomy of provinces. Would even a merely declaratory UK Health Act, specifying the importance of short waiting lists, or population health, or free markets, be welcomed as compatible with the values of the other health systems, or with the autonomy of Northern Ireland, Scotland and Wales? Internationally, the experiences of countries as diverse as Australia, Australia, Canada, Germany, Italy, Spain and the United States show us two things. One is that formal processes for the resolution of intergovernmental argument are crucial. The UK will be vulnerable in this respect because it has, by international standards, an astonishingly weak system of intergovernmental coordination and dispute resolution.[5]

The other requirement for productive intergovernmental debate is a spirit of understanding and recognition of shared values. That underlies any functional process of dispute resolution. Not only do intergovernmental relations tend to become embittered, intergovernmental conflict also tends to lead to central government victory if there is a lack of respect for divergent agendas. Recognition of shared and divergent values, which can be a tool for the central government to dominate devolved ones, can equally be a device for devolved ones to entrench their autonomy. And that is why discussion of values matters. Understanding of shared commitments, and respect for differences, is an intangible but important part of good intergovernmental relationships. Space for argument and respect – rather than the automatic assumption of the other's incompetence, parochialism and venality that usually marks intergovernmental conflicts – is key to accepting the divergence that does so much to justify devolution while highlighting any reasons not to diverge on some issues.

The third challenge: the European Union and values

The third challenge to peaceful differentiation is the importance of the European Union. Recognition is spreading of the significance of the EU in health policy, with substantial literatures in law and health policy on the subject.[6] The problem is simply stated: the EU is very poor at remaining within its assigned powers. Furthermore, in most areas that came to be subject to significant EU policy engagement, EU institutions' influence became enormous and very difficult for member states, elected officials or anybody else to truly control. This is because the key power of the EU is the power to create an internal market with freedom of movement for goods, people, services and capital. That power effectively gives the EU institutions the power to oversee any sector of the European economy – in the name of the free market. The fact that most EU 'health' policy is actually competition policy, or labour regulation, or single market law, that is developed by people outside the health world and then applied to it, creates more problems of conflicting goals, values and mechanisms.

Many of these can be understood in the context of a threefold tension. David Hunter, in his chapter here, identifies a tension between the EU as an internal market – easily the main source of its power and preferences – and as a social model, often invoked to justify it. There is a further tension, which is between Europeanisation, convergence and the integrity, popularity and good things about national models that might be incompatible with parts of EU law. The European Union institutions, particularly the European Court of Justice, enunciate some values (such as patient choice of provider) more strongly than any NHS system; say things that are currently more compatible with the NHS systems in theory than in current practice (such as when they talk of solidarity as a major value), and have approaches to many issues (such as professionalism) that are rooted in very different

ways of thinking. The third tension is between devolution and Europeanisation. There are areas of policy in which the powers devolved to Northern Ireland, Scotland and Wales are close to meaningless – as in fisheries, a topic on which Scotland's powerlessness within the EU greatly exercises the SNP. When a devolved policy area becomes Europeanised, power shifts from the devolved government to the EU institutions – and to the member states, whose power within the EU greatly exceeds that of any regional government. A devolved health policy subject to EU health law is one subject to the Brussels institutions, and secondarily the member states. Scotland or Wales must implement what they can within that framework. That is hardly what the framers of devolution, let alone Scottish or Welsh nationalists, sought.

All this friction has sparked a debate. It is taking place now, surrounding issues such as proposed legislation on health, and particularly important to those who try to influence the EU and engage in its debates, for the framework set for EU health law now is likely to be the framework of EU health law for a long time to come. The question for newcomers is simple: Is the goal of EU policy engagement to understand the world, or to change it?[7] Are we attempting to stabilise a legal framework created by policy overspill and an adventurous European Court of Justice, or should the goal of policy be to use the opportunities created by the EU and its direction of travel to create change? If the direction of EU policy is, for example, tied to the expansion of the internal market and competition law, then it almost certainly conflicts with values of universality, professionalism and public service as understood and practiced in the UK. David Hunter, in his contribution, identifies emerging values of the EU, as seen in pronouncements, policies and the jurisprudence of the European Court of Justice. The fit of those values with the ones enunciated across the UK systems should decide whether we seek minimally invasive legislation that will slow EU encroachment or take advantage of opportunities to remodel the continent and possibly the NHS systems. If the leaders of the health systems of the UK know what they value, and what values are emerging in the EU system, they will be better able to pick the fights that truly matter. They will be able to change it if they realise they must. Hunter also points out that it is a very elite debate. He concludes that it must be opened up: "Only then might the European project, which continues to remain somewhat moribund, be given new life and a renewed sense of purpose. What remains unclear is what will trigger this process – because it is most unlikely to happen of its own volition."

Understanding the values that are shared matters particularly here. The point of devolution may be divergence and recognition of the different values in practice. But the EU is a creature of member states. It accepts some policy diversity between its member states, but not political diversity within them. That means there is one UK position and vote. Northern Ireland, Scotland and Wales, even when they invest in influencing health

policy, are little more than lobbies which must work for access to EU policymakers, information and influence over the UK position. Articulating values that they share with the rest of the UK and the EU would help their ability to influence these debates.

What could the problem be?

The problem is simple: few health policymakers have grasped that devolution is about divergence in ends as well as means. This is a danger as much to the UK as it is to the autonomy of the devolved governments. It is a threat to the UK because shared values that might underpin a British identity for the future are not enunciated; it has never been clear what Prime Minister Brown has been talking about in his many speeches about the 'Britishness' of the NHS. It is also a threat to devolution. It is always, in territorial politics, a good bet that the central government will have more money, staff, information and flexibility and that over time it will use it to encroach on the autonomy of lesser governments. The defence of devolved autonomy will be easier and more civilised if shared ends are separated out and, if not celebrated, at least recognised. This is particularly pressing as the UK's institutions of intergovernmental relations are fragile.[8] Its financial formula is a spreadsheet in the Treasury and its government-to-government contacts, dignified by the name 'Joint Ministerial Committees' among others, are irregular, to say the least. When combined with lack of respect for divergent policies and policy goals, the result is a perfect recipe for Westminster hamfistedness and devolved anger.

"What rights should any baby in Britain have in common with a baby in Bulgaria?"

What matters for our purposes is that the health systems and the values contained within survive and thrive under devolution. It is that the shared values and divergent ones be best pursued and promoted. It is not that the divergence be reversed, or that any particular changes to devolution take place. This book has established that there are differences in both values and the way our political systems talk about values. The challenge is to make divergence and its consequences positive, and not negative, for health. The underlying question is how the UK will manage the tension between the logic of federalism and the logic of citizenship.[9] The logic of federalism is that territorial divergence is acceptable. For many, it is the purpose of decentralisation. Following this logic, different health systems are a good thing; if England, Northern Ireland, Scotland or Wales wants to be not just different but also better, that is its right. The logic of citizenship, and probably Britishness, is quite different. It is that all the people of the UK are equal. Scotland does not have any particular right to a better (or better-funded) NHS except insofar as its needs are proportionately greater. The question has the most

bite as the Canadian scholar Keith Banting puts it: should the treatment of a sick baby depend on where its parents live? Or do all the sick babies of the UK have the right to the same treatment, regardless of devolution (or territorial variation within England, Scotland or another place)? To what extent does the logic of citizenship mean the thin EU citizenship so beloved of EU enthusiasts? What rights should any baby in Britain have in common with a baby in Bulgaria? Will those rights be the purely negative ones that the Court can impose – to rights to pay and avoid waiting lists?

What is coming?

Greater devolved power and autonomy for all three devolved governments is likely in the near term but not inevitable in the medium term. So divergence, and divergent values, are ascendant now but may be storing up future problems for both health and devolution. Some greater devolved power and autonomy is highly likely in the near future: not only because Northern Ireland's Belfast Agreement schedules it for slow emancipation over time, but also because the conditions under which Plaid Cymru entered government in Wales in July 2007 included a commitment from Labour to call and support a referendum on greater powers for the National Assembly. There is public support for greater devolution of power; it is not hard to find polls supporting the proposition that Scotland and Wales should have more powers. It is not wise to put much weight on opinions about constitutional topics as revealed by public opinion polls; if there is an area in which mass public opinion is malleable and unreflective of attentive thought, it is the constitution. But we are already well down the path to a referendum on greater powers in Wales (a likely victory), and a referendum on independence in Scotland.

The most pressing questions are around finance.[10] Right now, the UK is funded by the much-misunderstood, intricate, indefensible and fundamentally simple Barnett formula. Barnett, a temporary fix from the 1970s that has been repudiated by its inventor (now Lord Barnett), allocates new spending on a per capita basis; for each new pound of government spending on England, the three devolved governments get an equivalent amount of new spending per capita. Barnett is a remarkable formula. It potentially leaves everybody aggrieved: the UK divides into those who can feel under-funded and those whose budget is being cut. It does nothing at all to address regional disparities within England. Nor does it address need; Wales has probably been under-funded relative to need since it started, and Barnett has been nibbling away at the Welsh budget allocation for all that time. The Barnett formula's only virtue as an instrument of fiscal policy is that it is a block grant, which is good for devolved autonomy – but there are many block grants with more solid bases. It is, in short, extremely hard to defend on grounds of need, democracy or efficiency. It is also under review from many quarters. BMA Wales has called for a review as part of any

solution to Welsh health problems. As of July 2007, calls for reviews and more or less formal reviews were starting. And, as is worth remembering, the formula has essentially no formal basis. It is within the power of the UK government to rewrite it tomorrow. When devolution finance is reviewed, Northern Ireland, Scotland and Wales will need to justify their distinctive values in a broad public court. That will be the values debate. It will be the values debate for which the *Daily Mail* is already preparing us – a debate about whether we can justify what it calls 'medical apartheid'. It will also be a values debate that could ruin today's spirited efforts to erect 'the NHS' into a pillar of Britishness.

Slightly less likely is an assault on the 'West Lothian Question', the anomaly that Scottish and Welsh MPs can vote on English policies (and be Prime Minister) but English MPs cannot vote on Scottish and Welsh policies. The underlying political arithmetic is simple: without Scottish and Welsh MPs, the Conservatives would be close to a permanent majority. It is naturally in the Conservatives' interest to promote English votes on English laws. It is naturally in the Labour party's interest to stress the unity of the UK parliament; otherwise they would have spent far less time in office over the last century. So far, the argument has been conducted on two levels: a high-level debate about constitutional law and procedure, and low-level mudslinging about a 'Scottish raj'. But key Blairite policies, including foundation hospitals, depended on Scottish and Welsh votes. How sustainable is that, especially now that a Scottish Prime Minister provides an attractive target for Conservatives?

What could be done?

The question, then, is how the UK should balance the logic of federalism and the logic of citizenship. To what extent should a sick baby's treatment be different based on where its parents live? And how can institutions help that balance be the one consistent with the values of the services and the populations?

If we look at the institutional arrangements of the UK, the answer is that the sick baby's treatment should vary. Devolution limits the freedom of Northern Ireland, Scotland and Wales to a few areas but it gives them great latitude in those areas. Scotland's latitude is enormous, because the formal powers of the UK government over it are very limited; Northern Ireland's is considerable, when it is operating; and the power of the National Assembly for Wales, scheduled to grow, has always been considerable in health because so much of power in health policy is use of the secondary legislative and other powers that it already has. So while the framers of devolution might not have been thinking it, they designed a system to treat that baby differently depending on where it lives. But if we look at public opinion, the answer is rather different. Public opinion in the UK is highly tolerant of divergence but shows almost no support for divergence in ultimate citizenship rights. The options are arranged in order of centralisation. They range from breaking up

the UK, through to the possibility of UK legislation that would essentially embed values (ideally shared ones!) in the constitutional settlement of devolution. All have their costs and benefits. And for all of them, the *way* in which they would be done would determine their effects.

Secession

National independence for Scotland is obviously a hotly contested topic, but it is a live possibility; the current governing party of Scotland is committed to hold a referendum on independence. That would decisively resolve a tension between the logic of British citizenship and the logic of divergence by eliminating shared British citizenship. And insofar as Scotland worked within a framework of shared values, it would be one developed within the EU and, perhaps, shaped by Scotland and the UK in alliance with other EU member states that shared systems and values. It would also be a good way to conclude the debate as to whether Scotland's higher per-capita spending – which helps sustain its health service – is a subsidy from the UK or a poor substitute for its oil revenues. Scotland is, though, the only part of the UK that seems likely to leave in the foreseeable future. The role of Wales in a UK without Scotland is imponderable. In an intact UK, Wales is unlikely to secede – even Plaid Cymru does not call for outright independence in the near future. Northern Ireland looks likely to continue its trajectory towards a sort of post-national orbit in which it remains part of the UK but is linked as tightly with the Republic of Ireland to its south as with the UK to its east. So even if Scotland leaves the UK, the problems do not all go away. The tension between different and shared values will remain, and can be better or worse handled.

Managing the status quo

The United Kingdom has survived for ten years with very informal devolved arrangements and a politics of persistent confusion about the meaning of the 'national' in the NHS. Why should it change? Or, better, why should it not just develop a stabler system of intergovernmental relations, one that channels conflict more productively, and accept both divergent and shared values?

There are strong arguments for a more structured system of intergovernmental relations. The strongest one is that it is very difficult to imagine the current system surviving. Dependent as it is on good intergovernmental networks and a will to cooperate, it starts to fall apart when Labour loses office. That means that since May 2007 it has been in trouble. Further, it is evolving towards what experts in comparative intergovernmental relations call 'executive federalism'. In executive federalism, governments and heads of government – First and Prime Ministers – dominate intergovernmental relations. Intergovernmental relations are

highly political, weakly structured, and often generate much more heat than light. This is the natural tendency of decentralised Westminster systems; it is also one that can undermine shared values in a perpetual storm of politics. Health, and other issues, can become pawns of politics. In some areas, including EU health representation, the superiority of Westminster is clear, and the devolved governments in Brussels are, without UK government cooperation, mere lobbies. Furthermore, it is a risky game for all governments; devolved ones can lose in bilateral summits as often as they win.

The solution can to some extent be found in formalisation: structured information-sharing and coordination, and agreed-upon rules for intergovernmental dispute resolution and EU policy formation. At the moment, information-sharing among officials is deteriorating in many areas, including critical ones such as communicable disease control and professional education. Information that once was shared by Labour networks is now much less useful. And if a conflict escalates, the law of devolution includes dispute mechanisms that might be wholly unacceptable (especially to devolved leaders).[11] Building more attractive mechanisms with more legitimacy would be a good start. But ultimately, dispute resolution mechanisms are predicated on disputes and can only soften power relations. That might be enough, but they do not respond to, or preserve, shared values.

A social union

One option is a consensual agreement among the governments of the UK that the Union truly has a consensual social dimension, instead of just a flag and political knowledge tests for new immigrants. The 'Social Union' is a term from Canada, where heated federal–provincial arguments about money and welfare standards are a long tradition. Given that Canada, with its combination of Westminster governments, nationalism and highly decentralized government is as plausible a model for the UK as any, it might pay to learn from one of its better innovations.[12] The Social Union refers to 'SUFA', the Social Union Framework Agreement, signed in 1999.[13] This was an effort to take some of the heat out of federal–provincial relations by signing an agreement that enshrined a number of principles, many of them about process and mutual respect. Key parts, for example, drive home that 'all Canadians are equal' and that the federal government's 'spending power', that is, its ability to use its money to shape policy in the provinces, should be used respectfully. It was promising: all the governments would agree on a framework to reduce friction in intergovernmental relations, commit to reduce disputes (implicitly, not pick fights for political reasons), channel arguments so that they would reduce the tension, and at least try to respect some shared values – such as the equality of citizens. It was at best a small and qualified success. Part of the problem was that the negotiations with Quebec went badly wrong, and what might have been a great breakthrough turned,

in Quebec at least, into an ambush of Quebec by the federation and other provinces. This robbed SUFA of its potential value by turning it into an anglophone imposition. The lesson of that is simple – the introduction of any shared system for intergovernmental relations, it if is to foment consensus, must be consensual. The bulk of the problem, though, is that any agreement is prone to erode as politicians pursue all sorts of local and partisan advantage at the expense of accommodation with their fellows. One provincial government official said that it was "an agreement about nothing".[14]

But there is hope: the UK lacks Canada's history of highly visible, highly political, federal–provincial trench warfare. The rules of the game are being written now. And an agreement on substantive principles and process – the reaffirmation of a social union – might be a valuable way to entrench shared values of the NHS systems, articulate them for a wider European audience, and enshrine their ability to diverge. The time for intergovernmental agreement might seem to have passed. But should a First or Prime Minister articulate a statement of shared values, and invite the others to join in, it would be interesting to see the excuses that could allow one to refuse.

A British Health Act

This is another Canadian idea, one that also embittered federal–provincial relations but is seen by many, in rosy retrospect, as a great victory. The idea is simple: the Canadian federal government imposed a statement of principles (backed by its financial stake in provincial health plans). The principles were simple. Canadian health systems must have public administration; comprehensiveness; universality; portability (between provinces); and accessibility (access). While they are backed by federal financial power, what really keeps provinces compliant is their symbolic force. They resonate with values on a deep enough level that no provincial government has dared break with the provisions of the Act. As Roy Romanow, a former provincial premier and leader of a major commission of inquiry into Canada's health put it in November 2002:

> *The principles of the Canada Health Act [CHA] began as simple conditions attached to federal funding for medicare. Over time, they became much more than that. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care. The principles have stood the test of time and continue to reflect the values of Canadians.*[15]

Implemented correctly, such an Act could entrench devolved autonomy. In an informal, unstructured system – particularly one that lodges power over finance in the central government – there are powerful forces eroding devolved autonomy. An Act that identified shared values and left others to diverge would be a powerful political message. While the

CHA was imposed, there are many other examples of such framework laws built into constitutions. Done wrongly, it could embitter British health politics. The problem is partly that the UK government, unlike the Canadian federal government, also runs a health service. Its performance to date suggests that any British Health Act written within Whitehall would be myopically English, if not myopically focused on the preoccupations and current management theories of London Transport Zone 1. The Scots and Welsh might ask why the UK government, which is likely to undermine what are still seen as key values, should be the custodian of the UK health services (for them, perhaps its virtue would be to trap the UK government into remaining close to these values). Furthermore, the constitutional issues are tricky. Health is a devolved power. The Scotland Act is especially clear about that. So the Act, to be something other than a radical and unilateral re-opening of constitutional law, would have to be consensual.

So it is an extremely risky option. It would be a change to the constitution. It would entrust the UK government with guardianship of values in health and roll back devolved autonomy. Given the divergence in values and the direction of health policy in England, that might not strike people elsewhere as a good idea at all. It might cement shared values and practices, but it could be disastrous for devolution, for the stability of devolution, and therefore for the UK itself.

Conclusion

It is axiomatic among disaster response and public health experts that most plans are useless in emergencies – but the process of planning is crucial. No plan can cope with the complexity of disasters. But planning opens the eyes of participants to the problems now, the resources available, the networks that do and should exist, and the kind of thinking that they might have to do. That intellectual preparation, more than any printed plan, is crucial when crisis hits. The UK has not planned for intergovernmental conflict. Lulled by shared Labour Party leadership and residual civil service networks, a curious notion took hold that lack of intergovernmental conflict was a sign that the system worked. As academics pointed out, to no visible effect, the lack of conflict was a transitory phenomenon. Rather than proving the essential solidity of the UK's system of intergovernmental relations, it enabled its further erosion. Insofar as policymakers perceived divergent values, they took that as an additional reason to ignore each other.

Nor has it (or any other EU member state) adapted to the challenges of EU health policy. The European Union's health policies, as discussed by David Hunter, are at a crucial stage. The range of values discussed in formal documents alone, as well as international collaboratives such as the one that produced the Madrid Framework, are very diverse. When we look for values in its concrete policies, the result is equally confusing – with

policies ranging from peer review and benchmarking through to European Court of Justice decisions that are barely respectful of the value-laden specificity of health. The range of options includes threats but overall poses an opportunity – the UK's health systems are now on an international stage, and can do a better job of articulating what matters.

Now, if we are to judge by the scant inches of coverage and thought that London papers give to 2007's major developments in devolved politics, even epochal changes are unnoticed. Only intergovernmental fights are coming onto the radar screen. The solidification of divergent values has taken place in solitudes – of London, Belfast, Cardiff, Edinburgh and Brussels.[16] This is partly a technical problem for intergovernmental relations, and partly a political one for ministers, but it is also a discursive one. Understanding the reach of values, their importance in politics, and the way we talk about shared and different values is important in shaping the future of health and devolution. Values, no matter how vapid, motivate us all, and in health, as in many other areas, a frank discussion of differing and shared values is much, much healthier than sniping or moralising.

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DEVOLVING POLICY, DIVERGING VALUES?

THE VALUES OF THE UNITED KINGDOM'S NATIONAL HEALTH SERVICES

Values are important for the success of any organisation, including the NHS. They clarify what an organisation stands for, how it will use its resources and how it will make decisions. Both devolution and the increased role of the European Union in health policy pose new challenges to our healthcare system. What is, and should be, at the ethical and practical core of the healthcare systems of the UK?

Devolving Policy, Diverging Values? aims to shape the debate about the shared and divergent values of the UK's national health services. The report focuses on the values of the NHS in each of the four nations, and those of health care systems within Europe. The report, edited by Dr Scott Greer of the University of Michigan, contains contributions from leading health policy analysts. It aims to contribute to the debate about how we define the values of our national health services in the face of both devolution in the United Kingdom and the development of the wider European Union. This report will be of interest to policymakers, healthcare leaders, and all those studying and researching healthcare, devolution or European policy.

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