HEALTH AND INTERGOVERNMENTAL RELATIONS IN THE DEVOLVED UNITED KINGDOM

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The Nuffield Trust
FOR RESEARCH AND POLICY
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About the Nuffield Trust

The Nuffield Trust is a charitable trust carrying out research and policy analysis on health services. Its focus is on reform of health services to increase the efficiency, effectiveness, equality and responsiveness of care.

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Alan Trench is now research fellow in the School of Law at the University of Edinburgh. He was formerly at the Constitution Unit at University College London, and remains an honorary senior research fellow there. A solicitor by profession (now non-practising), he has worked on aspects of intergovernmental relations and policy in the devolved United Kingdom and in federal and decentralised systems since switching to academia in 2001. His academic publications include *Devolution and Power in the United Kingdom* (Manchester University Press, 2007), and several volumes in the 'State of the Nations' series published by Imprint Academic. He also advises a range of bodies and organisations on the working and implications of devolution.

Foreword

Ever since devolution became a political reality in the UK, The Nuffield Trust has been researching its effects on health and healthcare. As the Appendix at the back of this report shows, the result is a rich body of work that provides a valuable insight into the effect of devolving responsibility for healthcare, both within and beyond the UK.

Central to improving how healthcare works, post-devolution, is understanding how policy-makers and Governments work together (or sometimes don't) to find solutions to the puzzles that devolution sometimes presents. That is the task that Scott Greer and Alan Trench have set out to achieve in this short report that forms the latest in the Trust's devolution series. That they succeed in this task is due not only to their expert understanding of both the legal and constitutional aspects of devolution, but also to the exhaustive series of interviews that they have carried out with senior policy-makers in England, Northern Ireland, Scotland and Wales. These interviews include those carried out specifically for this report alongside others from throughout the past decade. It is the resulting thorough understanding of both context and process that has enabled them to provide such a clear explanation of current issues, together with practical recommendations for the future.

As both healthcare and the shape of the UK's political landscape continue to evolve, the Nuffield Trust's devolution project responds accordingly. Published to coincide with the NHS' 60th birthday, Lord Darzi's recent report[i] emphasises the fact that the future success of the NHS depends in large part on measuring and improving quality. This focus on quality is of equal importance across the four

i. Professor the Lord Darzi of Denham (2008) *High Quality Care For All: NHS Next Stage Review. Final report*. Department of Health.

nations and forms another longstanding theme in the Trust's work programme. Following the recent publication of our major report on healthcare quality on England, *The Quest for Quality*, we are now focusing on a comparative study of the performance of NHS care across the UK, with a report due next year.

I hope *Health and Intergovernmental Relations* will be widely read, not just by policy-makers, but also by those within the medical professions and healthcare organisations whose work is likely to be influenced by devolution. The Trust will continue to play a major role in the debate about devolution and health.

Dr Jennifer Dixon
Director, The Nuffield Trust

Executive summary

Since devolution in 1999, the four health systems of the UK, always historically different and now enabled by devolution, have drifted further apart. Each is preoccupied with its own problems, agendas and policies. Health policy-makers, if they speak of devolution, tend to speak in terms of policy comparisons. In this context, intergovernmental relations does not seem particularly important to people in health policy, and specialists in intergovernmental relations often look blank when asked how health matters to what they do.

This report first outlines the institutional background of intergovernmental relations in health: how the UK constitution allocates powers over health policy, and how the four jurisdictions and the UK state fit together.

- 'Devolution' means different things in Northern Ireland, Scotland and Wales. The powers and internal organisation of the three bodies are different, and the powers of the Welsh Assembly Government, in particular, are confusingly interpenetrated with Westminster, and are rapidly changing.
- The current financing structure for devolution creates a level of devolved policy-making autonomy, but creates two problems. First, it is not underpinned by any kind of needs assessment, and the funding available to each administration may not be appropriate to the policy problems it has to deal with. Second, it constrains the autonomy and democratic accountability of the devolved governments by tightly limiting their powers over taxation and subjecting them to a financing regime entirely within the control of Whitehall.
- There are extensive overlaps and complexities in the devolution settlement. In practice it is difficult to carry out any given policy without some amount of intergovernmental cooperation.
- And in addition to the tensions from messy intergovernmental relations and a financial system that is difficult to justify, there are constitutional asymmetries. Most prominently, there is the 'West Lothian Question' – the simple fact that Scottish MPs sitting in Westminster can vote on English health policy but not on Scottish health policy – and that without them the Bill authorising foundation hospitals, among others, would not have been passed.

The result is a system that creates many opportunities for politicians or administrative error to create conflict.

The second section discusses health policy issues in intergovernmental relations. It identifies areas of potential conflict in and involving health care. It finds multiple stresses and strains that are creating, or could create, political conflict. Two of these stem from above:

- *Financing*. Any change in the English health budget would affect the devolved administrations' resources. Changes to the financing system overall (now firmly on the agenda for the medium term) would do so too.
- *The West Lothian Question*, the political term for the asymmetry that means a Westminster MP can vote on English health policy but not health policy in his or her constituency. Prime Minister Gordon Brown and Chancellor Alasdair Darling, for example, play a much larger role in English health policy than in the health policies affecting their (Scottish) constituencies.

It is all too easy to see the noxiousness of the present political cocktail: asymmetric representation, a funding formula that is difficult to justify, and different levels of services in different parts of the UK. The term 'medical apartheid' has already entered discussion in the *Sun, Daily Mail,* and Parliamentary debates.

Other areas of potential conflict are 'from below': they emerge from stresses and strains in the health services themselves:

- *Health legislation* itself is complex, particularly in Wales, where present arrangements have allowed Westminster MPs to be deeply involved in Welsh health policy-making. This will continue even under the new legislative arrangements.
- *Cross-border patient flows* cause a remarkable amount of administrative and political tension. They are a simple case of the friction that ensues when two neighbouring governments do not care much about each other and do not pay much attention.
- *European Union* health policy is very important and increasingly shapes the strategic environment of health policy. EU policy-making demands some level of devolved-UK cooperation, particularly if the devolved administrations are to be effective. That level of cooperation is not always present.
- *Public health* coordination is largely informal and bureaucratic, which is why the gaps and overlaps across devolved borders have not been a major problem yet. But any analysis of public health policy finds weak coordination capacities and fuzzy legal hierarchies.
- *Contracts* for doctors and other health service workers are UK-wide, vital to labour markets and expenditure – and under threat from a variety of sources.
- *Standards* are a latent threat: both the developing debate about 'Britishness' and pressures unleashed by the EU's patient mobility jurisprudence might create pressure for common standards, but this would also open up difficult political questions.
- *Regulatory organisations* are a complicated patchwork, with different sets of responsibilities in different countries. The costs of operating in different policy

environments and the political tensions created by their decisions are putting them under increasing strain.
- *Professional training and regulation* is a UK reserved power, but in practice cannot be separated from professional structures. These are changing in several ways, most prominently in recruitment (for example the MTAS problems)[1] and changing professional roles that differ from system to system. The overall system of the organisation of professional regulation may therefore be called into question.
- *Professional and representative organisations* are likely to be under increasing threat as a consequence of divergence in contracts, standards and regulatory organisations.

The third section examines the management of intergovernmental relations in health. It focuses on the mechanisms for identifying and resolving conflict, and finds they may not be adequate:
- They rely heavily on informal mechanisms, underpinned by general consensus of approach, overall shared interests, and mutual 'goodwill' between governments. This was the case when Labour dominated all three British governments (between 1999 and 2007), but is likely to be decreasingly true – even if Labour (or indeed any one party) is in office simultaneously across the UK again.
- The mechanisms also rely heavily on the UK Government's internal processes and conduct in relation to the devolved administrations. These are inadequate, and create a real danger of causing serious political strife due to problems at a relatively low bureaucratic level.
- Elected politicians are not involved in a way that enables them to take a strategic view of intergovernmental issues; the framework leads to engagement only on a tactical level.

The fourth section suggests some improvements:
- greater, and more systematic coordination between governments, including a resuscitation of the Joint Ministerial Committee in its 'functional format' for health
- preparation of a more comprehensive intergovernmental agreement setting out arrangements for the conduct of relations in the future
- better awareness of devolution matters for Department of Health and other Whitehall staff
- creating formal responsibilities at official level for administrative coordination between systems.

1. In 2007 the new MTAS (Medical Training and Application Scheme) experienced a series of highly public IT failures.

INTRODUCTION

After a brief flurry of curiosity and worry about 'holding things together' around the time of devolution, intergovernmental relations dropped off the agenda of health policy-makers. Similarly, health dropped off the agenda of those interested in intergovernmental relations. England, Northern Ireland, Scotland and Wales largely went their separate ways in health policy, and only a few people tried to compare them or consider them in the round.

That is because intergovernmental relations do not seem very important in the overall scheme of things in the health sector. Policy-makers in health have an extensive range of powers in each jurisdiction, and so devolved policy-makers enjoy extensive autonomy in health policy (especially in Scotland). Given that the systems were already different, with distinctive histories and cultures, it should be no surprise that their health policies, organisations, health policy agendas and even cultures are diverging. The Nuffield Trust has extensively catalogued and analysed the divergent policies and their consequences since before devolution; Appendix 1 lists these publications.

But how do they interact? And what might be the consequences for health policy? At least at first sight, few of the day-to-day issues that make up health politics in each system have an intergovernmental dimension. In fact, the way devolution works in practice means that all these questions do have intergovernmental aspects – but this has been masked by benign political circumstances and the effectiveness of professional networks. Issues include the financial bases of the NHS systems, EU lobbying and policy, communicable disease control and cross-border patient flows, and professional standards. Again at first sight, few of these have an intergovernmental dimension. However, these conditions may no longer work as they once did. As time goes by and systems become more distinct, the cohesion of professional networks is likely to weaken. Political circumstances have already changed, and the lack of formal 'glue' that is a legacy of the existence of Labour-dominated governments across Britain between 1999 and 2007 is already starting to lead to a different pattern of relations between Belfast, Cardiff, Edinburgh and London.

These forces are likely to become more pronounced and evident as time goes by, and the result may create real political and policy problems in the next few years. In other words, intergovernmental relations are a potential strategic problem and hazard for the UK as a whole. The problems range from the unstable financial basis of the entire devolution settlement – which obviously affects health policy – to the potential conflicts in regulation, stresses on professionalism and standards, and opportunities for political entrepreneurs to turn arguments about the constitutional future of the UK's components into a health policy issue through debates about 'medical apartheid' or 'unfair' spending.

This report examines these issues, in order to understand how they might be addressed in future. It outlines the formal structure of devolution and how this shapes intergovernmental relations affecting health policy (Chapter 1); health policy issues that have intergovernmental implications, and intergovernmental issues that impact on health (Chapter 2); how intergovernmental relations bearing on health now work (Chapter 3); and (in Chapter 4) our suggestions for improvements that would reduce needless disputes and try to make the remaining ones politically transparent. It draws on the authors' research on devolution and intergovernmental relations, which totals more than 400 interviews since 1997 among the policy-makers (mostly civil servants, health service managers or elected politicians) concerned with devolution from the institutional, legal, civil service or health policy points of view; these include a number of recent interviews carried out specifically for this report.

1. INSTITUTIONAL BACKGROUND: LEGAL AND ADMINISTRATIVE ASPECTS OF DEVOLUTION IN THE UNITED KINGDOM

Policies, politics and personal networks all depend on a framework of law and institutions, and the allocation of power and autonomy in health policy shapes the politics of devolution and health. This section sets out the institutional framework of devolution in the UK, and discusses how it has come to work since 1999.

1.1 The legal and administrative structure of devolution

As the way devolution works is in many respects different for each of Scotland, Wales and Northern Ireland, it is worth setting out what devolution means for each part of the United Kingdom.

1.1.1 Scotland

In Scotland, under the Scotland Act 1998 the Scottish Parliament has a wide range of legislative powers, and can legislate for all matters save those expressly reserved to Westminster. Reserved matters include such 'high politics' matters as defence and foreign affairs, the macro-economy and currency, and redistribution through social security. It also includes much regulation of the economy, including employment law, broadcasting, the research councils and medicines licensing. In order (presumably) to maintain integrated labour markets and common professional standards, the Act also reserved regulation for almost all health professions. Devolved matters are everything else – including most

aspects of health policy, as well as housing, education, the criminal law and policing. With the exception of xenotransplantation,[2] abortion, embryology and surrogacy, medicines licensing and most (but not all) medical professions, health is devolved.[3] Other relevant reserved matters include the research councils, health and safety at work and consumer products, social security and welfare benefits.

1.1.2 Northern Ireland

In Northern Ireland, the constitutional fabric of devolution is rather more complicated – not least because of the relationship between the devolved institutions within Northern Ireland set up under Strand 1 of the Belfast Agreement, the north–south institutions created by Strand 2 of the Agreement and the 'east–west' ones (the British–Irish Council and intergovernmental conference) set up by Strand 3. Under Strand 1, there are distinctions between 'reserved' matters, 'excepted' matters and devolved ones. As in Scotland, all matters not specifically reserved or excepted are devolved. 'Reserved' matters are ones on which the Northern Ireland Assembly may legislate with the consent of the Secretary of State, and which may be devolved at some future date. Reserved matters include many aspects of economic regulation, and policing and criminal justice (which there are plans to devolve in due course). Excepted matters include defence and foreign affairs, and economic matters. Slightly oddly (and for historic reasons), social security is devolved, but subject to requirements designed to ensure parity in benefits and entitlements between Northern Ireland and Great Britain. Devolved matters therefore again include health, housing and education.

A further feature of Northern Ireland is its distinct administrative structure, dating back to the establishment of the Northern Ireland Parliament and Government in 1922, and most clearly manifested by the existence of a distinct Northern Ireland Civil Service. This means that health policy (along with many other areas of policy there) is not entangled with what happens in other parts of the country in the way it is on the mainland.

1.1.3 Wales

Devolution to Wales has been in a state of flux since 1998. The Government of Wales Act 1998 created a National Assembly for Wales that was a single body corporate, combining representative and executive functions in a single entity. Part of the story of Welsh devolution has been the differentiation between the elected, representative (and now

2. Animal-to-human transplants.
3. 'Reserved' professions include doctors, nurses, midwives, pharmacists, veterinary surgeons, opticians, osteopaths, chiropractors and professions covered by the Professions Supplementary to Medicine Act 1960.

legislative) Assembly, and the executive Welsh Assembly Government. These became separate formal entities with effect from May 2007, although they have been distinct in practice, if not in law, since 2002.

The Assembly's powers were initially limited to executive matters, starting with those of the Welsh Office before 1999, and included most aspects of health services and health promotion. Its powers expanded and developed as Westminster passed legislation affecting areas in which the Assembly had functions between 1999 and 2007. The various powers devolved on the National Assembly between 1998 and 2007 are still devolved, but they passed to the executive (the Welsh Assembly Government) when the 2006 Act came into effect. The 2006 Act also enables the National Assembly to acquire legislative powers relating to specific 'matters' in 20 'fields', either directly by Westminster Act of Parliament or by a 'Legislative Competence Order' (LCO), an order in council sought by the Assembly and approved at Westminster.[4] Health, housing and education are among those 'fields'. Thus, potentially the National Assembly can acquire legislative powers over health, to go with the executive powers that have been devolved since 1999.

The process by which the Assembly acquires such powers is complicated, and likely to be protracted (only one LCO has so far been passed at Westminster, so it is early to say). Proposals can be formulated by the Assembly Government, a committee or a back-bench Assembly Member. If approved by the Assembly, these are subjected to pre-legislative scrutiny, in Cardiff Bay and at Westminster. Following that consideration, a formal proposal has to be tabled in the Assembly and formally submitted to the Secretary of State for Wales, who can decide whether to submit it to Parliament or not. (If he chooses not to, he has to give his reasons to the First Minister within 60 days, but faces no other sanction.) The proposal is then considered in both the Commons and Lords, and has to be voted on after a 90-minute debate. If rejected, that is the end of the matter. If it is passed, it is then for the National Assembly to legislate. An informed guess is that the whole process could take between 18 and 24 months from start (proposal for an LCO in the Assembly) to finish (an enacted Assembly Measure, as Assembly legislation at this stage is known).

Ultimately, after a referendum (which may happen as soon as 2011), the Assembly may acquire 'primary legislative powers' over the 20 fields specified in the 2006 Act. These would include extensive areas of health, specifically:

- promotion of health
- prevention, treatment and alleviation of disease, illness, injury, disability and mental disorder
- control of disease

4. For a discussion of the Government of Wales Act 2006, see Trench, A. (2006) 'The Government of Wales Act 2006: The next steps in devolution for Wales', *Public Law*, 4 (Winter), 687–96.

- family planning
- provision of health services, including medical, dental, ophthalmic, pharmaceutical and ancillary services and facilities
- clinical governance and standards of health care
- organisation and funding of the National Health Service.[5]

On the administrative level, each country has – and has long had – distinctive administrative arrangements. In Scotland and Wales, these have been built around the Scottish Office (established 1885) and Welsh Office (established 1964), which in turn have meant that in many respects the organisation of government and of health services has long been differently structured and arranged. None of this is a consequence of devolution: indeed, devolution has been largely shaped by earlier administrative devolution and decentralisation.

The overall picture is therefore one in which a different pattern of functions is devolved to each part of the UK. Asymmetry is a key feature of the system, but with most aspects of health being devolved in all three jurisdictions.

1.1.4 England

England remains largely outside the map of devolution. Attempts to establish elected regional government were pursued in a rather half-hearted way by the Labour Government between 1999 and 2004. In October 2004, proposals to establish an elected regional assembly in the North East were decisively rejected in a referendum there. Since then, plans to set up elected regional assemblies elsewhere have been abandoned, and the UK Government has moved away from other aspects of the regional government scheme espoused by John Prescott. In particular, it has announced that the present non-elected regional chambers (which often call themselves 'regional assemblies') will be dismantled. Various aspects of the regional agenda remain under discussion, including 'city regions'. The result is to leave London as the only part of England with elected, regional-level government – though it is worth remembering that, with a population of eight million, Greater London has almost as many people as Scotland and Wales combined. The Greater London Authority has some limited responsibilities for public health, and given that almost any area of policy has some public health consequences, it has been easy for the Mayor and organisations such as the London Health Commission to promote a 'London health policy' that has very little to do with the NHS.

5. Government of Wales Act 2006, Schedule 7, Field 9. There are important exceptions to this, including the regulation of health professions, abortion, licensing and pricing of medicinal products, genetics and xenotransplantation.

1.2 Financing the devolved administrations

While the constitutional aspects of devolution give very extensive powers to the devolved administrations, the allocation of finance to them works rather differently. The devolved administrations are funded by block grants from the UK Government, calculated using the widely-discussed (if often misunderstood) Barnett formula. The grants pay no direct regard to need. They are based on historic levels of public spending, as it applied when the formula was first adopted in 1978. The Barnett formula applies only to changes in spending, whether made from year to year (or Spending Review to Spending Review), or within a financial year.[6] Such increases are allocated when changes are made to spending on 'comparable functions' in England, on a *pro rata* basis according to the population of each territory in relation to England (and according to the extent of devolution of the function involved). The grant is an unconditional one, which the devolved administrations are free to spend as they wish. (In the 2007 Comprehensive Spending Review, obligations were introduced to require part of the grant to be spent on capital investment, although what functions it is spent on is a matter for the devolved administrations.) Thus, there is no identifiable element of the grant relating to health, education, or any other function, and increases in grant triggered by increases in spending on a particular function in England do not have to be spent on that function. The policy autonomy that the devolved administrations have as a result is extensive, and something that their officials prize highly. That said, there is often political pressure to increase spending on a function if the UK Government does so for England.

However, the block and formula system means that the devolved administrations have limited scope to increase the resources available to them. The devolved administrations have very limited borrowing powers (essentially only for cash-flow management), and very limited tax-raising powers. The Northern Ireland Assembly and National Assembly for Wales have no such powers, while the Scottish Parliament has a power, as yet unused, to vary the standard rate of income tax by up to three pence in the pound. If fully used, that power would raise about £1.1 billion (according to the 2007 UK Budget report), or about 5 per cent of total Scottish devolved spending of £21 billion.

Despite this, UK Government spending remains highly unequally distributed across the UK. Table 1 shows the varying levels of per capita spending in the four constituent parts

6. The best short introduction to how devolution finance works is Heald, D. and McLeod, A. 'Beyond Barnett? Funding devolution' in Adams, J. and Robinson, P. (eds) (2002) *Devolution in Practice: Public policy differences within the UK*, IPPR. See also McLean, I. and McMillan, A., (2003) 'The Distribution of Public Expenditure across the UK Regions', *Fiscal Studies*, 24 (1), 45–71. The formula is formally set out (now) in HM Treasury (2007) *Funding the Scottish Parliament, National Assembly for Wales and Northern Ireland Assembly: Statement of funding policy October 2007*, The Stationery Office.

of the UK. (Spending is also very unevenly distributed across England.) Spending levels are notably higher in Scotland and Northern Ireland than England or Wales – and while the nominal amounts spent on health in Scotland, Wales and Northern Ireland are higher than in England, these still account for smaller shares of public spending in those territories than they do in England.

Table 1. Total identifiable expenditure on services by country in 2005/6[7]

	Public spending per head, £	**Health spending per head, £**	**Health spending as percentage of total public spending**
England	6,835	1,437	21.0%
Wales	7,784	1,513	19.4%
Scotland	8,179	1,643	20.0%
Northern Ireland	8,713	1,549	17.7%
UK average	7,049	1,462	20.7%

Source: from HM Treasury and Office for National Statistics (2007) *Public Expenditure Statistical Analyses 2007*, Cm 7091; The Stationery Office, Table 9.11.

While there is considerable dispute among politicians and economists about what 'need' is and how it should be measured, there is a very common view that Scotland is over-funded in relation to its needs, and that Wales is under-funded. By most indicators of need – measures like per capita income (GDP: gross domestic product, or GVA: gross value added), levels of unemployment, and so forth – Wales has a much higher level of need than most of the rest of the UK. (So do parts of England, notably the North East.) By these sorts of measures, Scotland has much lower levels of need. Consequently the formula is widely criticised, and has been repeatedly disowned by Lord Barnett whose name it bears. The view that it does a disservice to Wales has led to the decision of the Welsh Assembly Government to establish a commission to look at the Assembly's financing and related powers, announced in June 2007, and a manifesto commitment of Plaid Cymru at the May 2007 elections.

However, it is important to remember that by no means all public spending in Scotland, Wales or Northern Ireland is distributed by the devolved administrations. The UK Government is still responsible for large amounts of public spending in each territory; in 2003/4 in Wales, the National Assembly accounted for only about 48 per cent of identifiable public spending; in Scotland the Scottish Executive for about 56 per cent; in

7. 2005/6 was the most recent year for which data is available from National Statistics at the time of going to press.

Northern Ireland the proportion was about 57 per cent (if social security spending is excluded; with social security, it is about 85 per cent). NHS pensions also constitute 'annually managed expenditure', which falls outside the scope of the Barnett formula. 'Identifiable' public spending excludes spending on defence, overseas aid and foreign affairs, but includes policing and prisons (the main difference between Scotland, where it is devolved, and Wales, where it is not), and social security and other welfare benefits (not devolved in Scotland or Wales).

1.3 Devolution and the UK institutions: Whitehall and Westminster

1.3.1 Legislation and the Sewel convention

Devolution has not affected the powers of the UK Parliament. Westminster remains sovereign as a matter of law, and as a matter of practice is still active as a legislature for all parts of the UK, even where legislative powers have been devolved.[8] In doing so, it acts in accordance with the so-called Sewel convention (named after Lord Sewel, who first stated it when a Scottish Office Minister in 1998), that Westminster 'would not normally legislate with regard to devolved matters except with the agreement of the devolved legislature'.[9] So far (thanks to Wales's limited legislative powers and the protracted suspensions of devolution in Northern Ireland) the convention has chiefly applied to Scotland, where it was extensively used between 1999 and 2007. What the convention means is that Westminster legislates – but Holyrood (or Stormont, or Cardiff Bay) votes to approve Westminster's use of its power to legislate on this occasion. The granting of such consent does not alter the devolved legislature's powers, and if it wanted to, it could repeal the UK legislation at some future date. Whether that would be practical is a difficult question; many cases of use of the convention arise where provision needs to be enacted on a UK- or Great Britain-wide basis, and the interference with devolved functions is limited and a consequence of substantive changes for England or England and Wales.

Part of the reason for this is that Westminster legislation frequently continues to deal with a wide range of territorial issues, with limited differentiation between the territorial scope of the various provisions contained in a single bill. Working out the actual (rather than formal) territorial extent of a bill is extremely difficult, not least because certain parts may

8. In addition to the references discussed above (notably Trench, 2006), see contributions to Hazell, R. and Rawlings, R. (eds) (2005) *Devolution, Law Making and the Constitution*, Imprint Academic, on issues relating to legislation.
9. HM Government (2001) *Memorandum of Understanding and Supplementary Agreements between the United Kingdom Government, Scottish Ministers, the Cabinet of the National Assembly for Wales and the Northern Ireland Executive Committee*, Cm 5240; The Stationery Office, para. 13.

apply in Wales only while one or two clauses may have a limited effect in Scotland – and parallel legislation will be made for Northern Ireland in the form of an order in council.

Following a review of the procedure by the Scottish Parliament's Procedures Committee in 2004, these motions are now known there as 'legislative consent motions'.

1.3.2 Whitehall and devolution

A further problem is that, in much of Whitehall, there remains an extensive overlap between devolved and non-devolved matters. Most UK Government departments deal with both, and make little structural attempt to distinguish between the territorial impact of their functions – so departments, divisions, branches and even units will combine England-only, England and Wales, Great Britain-wide and UK-wide functions. Few service departments retain the 'devolution' or 'constitution' desks they had between 1997 and 2001. Exceptions include the Foreign and Commonwealth Office and Ministry of Defence, which have minimal overlaps with devolved functions, and the Home Office. The Department of Health had a 'constitution unit', responsible for dealing with devolution and other aspects of the Labour Government's constitutional reform programme, but that was wound up in 2001. The Treasury has a team dealing with 'Devolved Nations and Regions' but its functions extend beyond applying the Barnett formula to funding Scotland, Wales and Northern Ireland to regional policy within England, and also the 2012 Olympics. The only mechanisms that try to distinguish between devolved and non-devolved matters are various internal procedures, most notably those relating to the preparation of legislation. These require various forms of consultation with the devolved administrations. They have made life for officials in service departments more complicated than before 1999, but have not radically changed it. Otherwise, devolved functions and non-devolved ones overlap with one another.

Unlike some other decentralised systems around the world, there is no central office to coordinate relations between the UK Government and the devolved administrations. In principle the Ministry of Justice now handles that, and has tried to beef up its ability to coordinate policy in recent months. This complements the work of a cabinet committee on the Constitution chaired by Jack Straw, Secretary of State for Justice and Lord Chancellor, which started to take a more active interest in devolution issues in the latter part of 2007, and which has been heavily involved in determining the more active constitutional policy that emerged in February and March 2008. However, this is concerned with constitutional matters – not more routine ones.

In general, coordination – and advice about what the devolution settlements mean – is the task of the Scotland and Wales Offices, which were scaled down after 1999 and now handle bilateral relations between the UK Government and the devolved administrations.

Neither is large. Until January 2008 each had a part-time Secretary of State who combined the job with another substantial portfolio (Work and Pensions for Peter Hain, who was also responsible for Wales, and Defence for Des Browne, who remains responsible for Scotland). Since January 2008 Paul Murphy has not combined the post of Secretary of State for Wales with any other ministerial portfolio.

Much of the work of those offices is in fact to act as an 'honest broker' in resolving differences that arise – which often includes explaining to other Whitehall departments what the devolution arrangements actually mean. That role is important but mostly requires attention at official level – it does not call for a heavy input of time from Cabinet Ministers. (The Northern Ireland Office is much less active in this respect, largely due to the greater administrative distinctiveness of Northern Ireland.) This approach does mean that no part of the UK Government is charged with taking an overall view of the working or implications of devolution and the UK's territorial constitution. As the UK's system means that policy issues can easily turn into constitutional ones, and vice versa, there is a need to join the two up.

1.3.3 The West Lothian Question

Devolution means that the three devolved bodies are responsible for the bulk of health policy in their territories, but the generally elected UK Parliament and Government are responsible for English health policy. The same problem arises in many other areas of domestic policy as well, and has given rise to a major constitutional anomaly, the so-called 'West Lothian Question'. Scottish MPs sit at Westminster and vote on matters affecting England, but not on ones relating to Scotland. These votes have proved decisive on a number of occasions, when controversial Government proposals for England needed those Scottish votes to pass. Examples include legislation for variable university tuition fees and foundation hospitals.

The foundation hospitals policy was a particularly salient issue. It was highly controversial, freeing some NHS trusts from the ordinary line management function in the NHS and permitting them to compete. It was the crux of a large Labour Government agenda aimed at introducing more competition and private sector-style behaviour into the English NHS. Passed in July 2003, with Prime Minister Blair's future arguably riding on it, it had faced a large rebellion among Labour MPs. The result was that it passed, but the number of Labour MPs from Scotland and Wales who voted for it was greater than the margin of victory. It was one of the first major England-only policies passed with a majority of UK but not English MPs (the Scottish National Party, which normally abstains from votes on England-only policies, chose to vote against foundation hospitals, with the declared justification that it might have Barnett formula implications). In fact, it involved the use of Scottish and Welsh MPs to force through a policy that was not only opposed by

the majority of English MPs but was also firmly ruled out by the (Labour-led) Governments in both Scotland and Wales. Scottish and Welsh MPs at Westminster were instrumental in imposing on England a policy that Scotland and Wales refused, largely out of party loyalty (as they were personally immune from any hostile constituency reaction to it). It is not hard to see why a majority of English MPs – or many interested onlookers in England – were aggrieved.

There are in fact Scottish interests in such matters, which are often overlooked; one is that when a proposal for England has financial implications, it will trigger consequential payments under the Barnett formula. Another is that such matters may in fact extend to Scotland, if the Sewel convention means that the Scottish Parliament has agreed to Westminster legislating on the matter. Nonetheless, this is a significant constitutional anomaly, and one that the UK Government has not sought to resolve. Although the number of Scottish MPs has been reduced (from 72 to 59), this just means that Scotland is no longer over-represented compared to England – it is represented only on a similar basis. Indeed, as Wales acquires legislative powers and Northern Ireland becomes more used to exercising its powers, the likelihood has to be that the anomaly will become more evident and more controversial. The Conservative Party has suggested moving to a system of 'English votes for English laws' to address the issue, and more recently Sir Malcolm Rifkind has advocated using an 'English Grand Committee' for part of the Parliamentary consideration of measures affecting only England. However, this would present grave practical problems of implementation, and risk creating two different majorities at Westminster, one for matters on which Scottish (and other devolved) MPs could vote and one for matters on which they could not. The result might well be to make the UK ungovernable.

1.4 Lessons from abroad

Devolution in its UK form is unlike federal, regionalised or decentralised systems in other countries. The UK's acute asymmetry is one reason for this; another is the high degree of continuity between the way things worked before 1999 and the way they work after devolution. In health, this is increased by an exaggerated belief in the autonomy Scotland and Northern Ireland, in particular, had before devolution.

Despite these differences, it is worth casting an eye at how intergovernmental relations work in other systems like, say, Canada, Australia or Spain. All such federal or regionalised systems differ a good deal from each other, but they demonstrate a common pattern in how the process of intergovernmental relations are managed, in the issues that arise and in the strategies and tactics used by governments, and individual policy-makers and actors, within them. Such intergovernmental relations have been described by one influential Canadian

observer as 'quasi-diplomatic', which is certainly a useful shorthand, even if it implies a greater degree of distance between governments than is the case. Other terms (in federal systems) used include 'executive federalism' and 'cooperative federalism'.

This pattern involves:[10]

- the use of regular inter-ministerial meetings between functional ministers (health, education, finance, and so on)
- an extensive pattern of official-level coordination to prepare for such meetings, through meetings of officials ranging from departmental heads (permanent secretaries or equivalent) down to working-level officials (equivalent of Grade 5 or Grade 7 in UK terms)
- beyond that, and varying from sector to sector, the development of a 'concertation reflex' between officials in regional or state-level governments, whose immediate response to any new or difficult issue is to contact their counterparts in other governments, establish their views and seek to coordinate responses in relation to the federal/central government
- occasional summit meetings of first ministers and political heads of government, although federal/central government heads tend to be less enthusiastic about such meetings than the heads of regional/state-level governments
- on the substantive level, attempts by the federal/central government to 'lead' regional/state-level governments, whether by use of money, constitutional powers, other government resources (such as research and policy-making capacity) or simple persuasion to follow the federal/central government's lead – efforts which are often resisted by regional/state governments, but which nonetheless shape the overall policy-making environment
- regular tussles about constitutional powers, and the distribution of finance within the state
- in multinational states (such as Canada with Quebec, Spain with Catalonia and the Basque Country, and, particularly, Belgium with Flanders) the emergence of any 'national' programme or policy is an object of contention for symbolic reasons, even if there are no substantive objections to it; it therefore becomes a challenge for the central state to initiate a 'national' policy, and requires both artfulness and political will to do so.

This does not mean that procedural intergovernmental relations are an unqualified good. There are two main sources of criticism. One is that they act as a *de facto* source of

10. A fuller analysis can be found in Trench, A. 'Intergovernmental Relations: In search of a theory' in Greer, S. (ed.) (2006) *Territory, Democracy and Justice: Regionalism and federalism in Western democracies*, Palgrave Macmillan, pp. 224–56.

pressures for centralisation, providing further channels for a central or federal government to exercise influence over regional or state governments. This criticism assumes that the process of intergovernmental relations causes such pressures, which exist anyway; what quasi-diplomatic intergovernmental relations do is to channel such pressures in a more coherent form, and to enable regional or state governments to combine to rival the influence of the federal or central government. The second line of criticism is that such intergovernmental relations privilege executives over legislatures, and amount to a 'third level' of government that is neither federal/central or state/regional, and beyond the control of the elected arms of government in either level. This criticism (associated particularly with the Canadian scholars Richard Simeon and David Cameron[11]) is an important one, and rightly emphasise the lack of accountability such relations can lead to – but this is a problem that is substantially capable of being remedied by vigilance on the part of legislatures, and by electors' use of the ballot box to remove governments that they think have done a poor job.

This is a very short summary of such issues, to which considerable elaboration and qualification could be added. Its point is this: the UK has so far demonstrated very few of these characteristics. The political and bureaucratic actors involved appear not to understand that these are normal ways of operating in decentralised or federal systems, and that their counterparts in many other systems have found themselves working in this way because the nature of the political processes at work mean that these are efficient and easy to use. The UK's resistance to them is, in this context, puzzling – the more so as several of them are part of the established repertory used for dealing with the European Union.

11. See for example Simeon, R. and Cameron, D.R. 'Intergovernmental Relations and Democracy: An oxymoron if ever there was one' in Bakvis, H. and Skogstad, G. (eds) (2002) *Canadian Federalism: Performance, effectiveness, and legitimacy*, Oxford University Press.

2. WHY CARE ABOUT INTERGOVERNMENTAL RELATIONS IN HEALTH?

The devolution settlement and constitution may be full of loose threads, but do people engaged with health policy need to entangle themselves? For a decade, the answer has usually been 'no'. But the growing frictions and disconnections are increasingly coming to affect – and shape – health policy, and to more often present strategic problems to policy-makers, managers and professionals.

We divide the issues into 'top-down' and 'bottom-up' issues. With 'top-down' issues, health is part of a larger game that politicians are playing. For these, we examine the possible consequences for health policy of a larger argument. By contrast 'bottom-up' issues are the ones that emerge from the field of health, and which may put the broader system under strain.

2.1 Issues from above

Health politics does not always explain health policies. Major policy and political decisions come about because of broader pressures, such as government budget constraints, and smaller pressures, such as the need to move politicians in a government. Devolution is a perfect example of non-health politics affecting health policy. Scotland and Wales have autonomous health policies because of the success of their devolution campaigns, not because of a technocratic health policy argument. This means that health policy-makers must be sensitive to storms that begin far from health policy debates but, when they arrive, can hit with hurricane force.

2.1.1 Finance

As discussed above, the present financial system for devolution was adopted out of convenience and a desire to minimise the impact of devolution both politically and administratively. However, such a system is increasingly ill-suited to the system that has arisen; it minimises financial accountability and responsibility for the devolved administrations, even if it does give them substantial policy autonomy. It is hard to understand, and its lack of transparency gives rise to a problem of legitimacy. It also lacks supporters among the devolved administrations: Scotland (which does well out of it, by any standard) seeks a greater degree of fiscal autonomy, Wales (which does quite poorly) wants a system that recognises its needs more fully, while Northern Ireland (which does very well on a per capita basis, but claims not well enough given its needs) wants both more funds and more fiscal autonomy.

Meanwhile, there is increasing resentment in England. This arises both in 'recipient' regions like the North East, North West and West Midlands, which do poorly given their levels of need (and in the North East's case poorly by any standard), and in 'donor' regions like London or the South East, which generate the prosperity redistributed to western and northern parts of the country. How this plays out remains unclear; the UK Government has strongly resisted any sort of review of the Barnett formula to date, but has applied and re-stated it following each Spending Review or Comprehensive Spending Review. Yet such a review will come sooner or later, given the political pressures at work. In particular, the Welsh Assembly Government announced in June 2007 that it would set up a commission to look at the Assembly's funding, including tax-varying and borrowing powers, though a chair had still not been named by the end of January 2008. Wendy Alexander has also launched consideration of financial issues as part of her proposal for a 'Scottish Constitutional Commission' endorsed by the Scottish Parliament in December 2007, to be chaired by Sir Kenneth Calman. When these bodies report, it will be very hard for the UK Government to avoid a substantive response.

One effect of the failure to open larger issues of finance for discussion is that second-order issues become the focus for discussion. These include such matters as whether particular spending increases for England attract consequential payments under the Barnett formula, what the baseline for increases actually is, or what measure of end-year flexibility applies in carrying over unspent funds from one year to the next (and how those might be spent). All these were points at issue during the 2007 Comprehensive Spending Review, as was the issue of whether the Treasury could require the devolved administrations to commit to certain levels of capital spending within their block grants, rather than being free to spend it as they wish (which promotes current rather than capital spending). Such second-order issues are likely to become bones of contention so long as the UK system remains as overlapping and intersected as it is.

2.1.2 Legislation

Legislation, particularly at Westminster, presents a number of problems. One set relate to the West Lothian Question, and the fact that this constitutional anomaly is becoming an increasing source of contention, while all the prospective solutions create as many problems if not more. As discussed above, it has already meant that Scottish MPs gave the foundation hospitals legislation its majority in Parliament over the opposition of a majority of English MPs. Some of the proposed solutions (the stronger variants of 'English votes for English laws', favoured by the Conservatives at the 2001 and 2005 UK general elections) could make the UK ungovernable, as there would be different Parliamentary majorities depending on whether the issue affected England only, or other parts of the UK as well. A second set relate to the Sewel convention – what this means, and what would happen if the UK Parliament were to legislate for devolved matters without the Scottish Parliament's consent.[12] More broadly, there is the question of what the role of Scottish or Welsh MPs at Westminster now is.

These issues may raise problems for health in two ways. First, health is as likely as any other policy sector – and, given public interest, more likely than many – to provide the case that causes serious disputes about these major issues arising from devolution. Such a row will not really be about health issues, but that is how it will be presented, and possibly how the media will treat it. We can already see this with press and Parliamentary discussions of 'medical apartheid'.[13] Second, spill-over from these issues will affect health, if the major row we anticipate arises because of another policy sector like education. The same principles that apply to such other 'domestic' sectors are likely to end up being applied to health as well.

2.1.3 Wales

Wales creates particular complexities. The Welsh Assembly Government already has extensive executive powers in the field of health (including all the powers devolved to the National Assembly before 2007). The Government of Wales Act 2006 means that until the National Assembly acquires 'primary legislative powers' (which requires approval at a referendum, and that is unlikely to be held before 2011) convoluted legislative procedures apply. The National Assembly can legislate for health matters where it has powers to do so, but it needs to acquire those powers first. That can happen through an Act of

12. Westminster legislation subject to the Sewel convention and relating to health included the Health and Social Care Act 2001, the NHS Reform and Health Care Professions Act 2002, and the Health and Social Care (Community Health and Standards) Act 2003.
13. Consider the handy clip-and-save guide to devolved health differences published in *The Sun* on 10 January 2008. Under the headline "UK's Medical Apartheid" it listed each health system and enumerated what "You Get", with examples such as "more drugs" in Northern Ireland, "free cancer drugs" in Scotland, and "shorter waiting times" in England.

Parliament at Westminster, or by the Assembly initiating a request for such powers through a Legislative Competence Order (LCO).

The upshot is that ideas for legislation starting in the Assembly concerning an area where the Assembly does not yet have powers will need approval in Westminster and Whitehall as well. Neither can be taken for granted. These arrangements have only been in effect for six months, but already there have been a number of cases where Whitehall departments have been uncooperative about devolving legislative functions when the Assembly has sought them. The scepticism about devolution of many MPs from Wales (on both the Tory and Labour benches) may lead to problems in Parliament too. That is before the matter reaches the National Assembly – where the Assembly is still struggling to develop its understanding of legislation, and where the legislative procedures are largely untested. And even when all goes smoothly, it is likely to take around two years between the serious tabling of a proposal for legislation (in the form of a draft LCO in the Assembly) and the final passing of an Assembly Measure, given the legislative procedures that have to be followed in Cardiff Bay, Westminster and then back in Cardiff Bay.

So far, the Assembly has shown only limited interest in acquiring powers in relation to health. The first Measure before the Assembly is on health – the NHS Redress Measure, which will lead to a system for resolving smaller-scale complaints without litigation. It parallels the NHS Redress Act 2006 for England (which conferred the appropriate powers on the Assembly). Otherwise, the Assembly has not sought legislative powers over health whether by LCO or by provision at Westminster. (Notably, it has not sought such powers in the Health and Social Care Bill, before Parliament in the 2007/8 session.) But this may well change. The 'One Wales' coalition agreement between Labour and Plaid Cymru concluded in June 2007 contains, in Chapter 3, extensive commitments on health matters. The question will be whether the existing executive powers are adequate to achieve these (and whether the Assembly has enough funds to do so), or whether it needs legislative powers too.

In any case, what before 2006 was already a messy and complicated system for Wales is becoming even messier and more complicated. The National Assembly has an incomplete patchwork of legislative powers, conferred by at least two different routes and taking many different forms (some broad and general, others narrow or subject to complicated exceptions). The executive powers of the Welsh Assembly Government are broader, and conferred both by Westminster legislation and laws made in Cardiff Bay. Even lawyers find the situation confusing and hard to understand; the difficulties for policy-makers, health professionals or the general public are all the greater.

2.2 Issues from below

Then, there are the issues from health policy itself: the problems that emerge when four distinctive systems must rub along together. The friction can create political and policy problems that intergovernmental relations must manage. The existing bureaucratic and political structures often fail to manage them.

2.2.1 Cross-border flows

This is the most basic problem, one that was widely anticipated. It is primarily a Welsh–English problem. About 13,000 Welsh patients are treated in English hospitals each year, and 7,000 English patients in Welsh ones. It is the first problem Wales Office officials mentioned when asked about intergovernmental relations in health. It produces a remarkable amount of heat for an administrative problem that should be fairly straightforward to resolve – governments paying for services provided to their citizens. The problem is simple: the priority of the DH is not Wales, the priority of the Welsh Assembly Government is not the DH, and managers on both sides of the border must put a priority on financial balance rather than cross-border comity. Given that there is no structure in place to deal with cross-border administrative issues, conflicts between two NHS organisations on different sides of the border tend to become heated, and escalate to inappropriate levels of both bureaucracy and passion. And so the chief executive of the Shrewsbury and Telford [hospital] trust could recently testify before the Commons Welsh Affairs Committee that "I am not getting a fair deal to the tune of £2 million" – in other words, that his trust plans on the basis of a contract for Welsh patients and is not paid appropriately.[14] It is not hard to see how such numbers at the level of an individual trust could make managers angry. The DH is presently considering a reformed organisation for the management of cross-border payments, but there is a threat that the best will be the enemy of the good – that efforts to rethink the system within the DH will simply delay smaller and simpler administrative responses. Any new systems will require the Welsh Assembly Government's agreement as well.

This issue may assume even greater importance in the coming months, if (as appears to be in the wind) Welsh Labour MPs seek to use such issues to emphasise the value of the UK Union as a whole, rather than just accept this as a technical issue of the sort that arises whenever there is a border, and which therefore simply needs a technical resolution.

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14. 18 March 2008 oral evidence to the Commons Welsh Affairs Select Committee by Tom Taylor. This is part of an ongoing inquiry into cross-border services. To be published as HC 401-ii; uncorrected evidence is at www.publications.parliament.uk/pa/cm200708/cmselect/cmwelaf/uc401-ii/uc40102.htm , accessed 1 April 2008.

2.2.2 The European Union

Nobody in the UK, or most member states, or most health policy communities, wanted an EU health policy. That does not mean they have not got one. The European Union has, since 1998, been extending its internal market, competition and procurement law into the health sector. The four NHS systems, needless to say, are not compliant with most imaginable EU frameworks, and it might cost them a great deal to adapt so that they comply with rules on state aid or a European Court of Justice definition of an acceptable waiting time. The result is that EU policy affects the strategic future of all health systems. That includes the devolved health systems, which are liable for the consequences of non-compliance with EU law (including any financial implications that arise, whether to the UK Government or individual patients).[15] That is a problem for devolution because the EU has two representative institutions: the European Parliament which represents voters, and the Council which represents the member states. In the Council, it is the UK that has votes, not Scotland or Wales, so if Scotland or Wales have a preference in EU health policy, they will be strongest if they prevail on the UK Government.

It is possible to overstate the importance of member states in EU policy-making. If it were up to the UK – or any other EU member state – there would be almost no EU health policy. Influence over the UK's position does not necessarily mean influence over EU policy, if the UK is either isolated in the Council or looks like an outlier to the European Court of Justice (which is notoriously unfriendly to states with distinctive paths). But even if they do not win every battle, the member states are still among the most powerful actors in Brussels, though they lack the power of either the Commission or the Court to shape the policy agenda. Influencing a member state government is one of the most effective things a stakeholder can do if they do not have the ear of the Commission or the sympathy of the Court.

The problem the devolved administrations face is that, in Brussels, Northern Ireland, Scotland and Wales are considered to be 'regions' like the regions of France or Länder of Germany. And regions as such are little more than lobbyists; their consultative body in the EU, the Committee of the Regions, is generally ineffective and has been largely abandoned by more significant regional governments. At the same time, Brussels is on track to surpass Washington as the most-lobbied city on earth. So while political disagreement or a desire for recognition might mean a devolved administration must strike out alone in Brussels, the result is likely to be less impressive than if it were to be working with and within the UK. The point is simple: it is very useful to be able to work through and with a member state government.

15. Greer, S.L. (2006) *Responding to Europe: Government, NHS and stakeholder responses to the EU health policy challenge*, The Nuffield Trust.

Britain's three devolved governments have done well compared to most European regions. This is partly because of the size and professionalism of their Brussels offices – but also because they successfully work with the UK permanent representation, are integrated into UK decision-making (notably through the Joint Ministerial Committee (JMC) for Europe, the one active 'functional format' of the JMC), and thereby can enjoy some of the tools of a member state as well as the tools of a regional lobby.[16] By contrast, a regional Brussels office acting alone might issue impressive documents, but will often fail to achieve its aims in practice.

The problem with this approach is that it depends on the ability of the devolved administrations to persuade the UK Government of their case. Even before May 2007, when Labour dominated all three governments, this was often problematic – as illustrated when a draft report by Michael Aron, head of the Scottish Executive's Brussels office, was leaked to the press in January 2007. The Aron report suggested there were significant problems, largely because of Whitehall's failure to consult in good time or to pay due regard to Scottish concerns. These difficulties will have become all the greater with the entry of nationalist parties into government, the different views of the policy issues at stake that they have (or are willing to express in public), and (especially for the SNP) the symbolic importance of being active on the European stage.

What therefore arises is a situation in which the intergovernmental mechanisms of influence and coordination are creaking somewhat, while the European Court of Justice may intervene in uncontrolled and unexpected ways. And if this system creates problems for the UK Government, those may be all the worse for the devolved administrations.[17]

2.2.3 Communicable disease control

Intergovernmental relations in communicable disease control work well, currently, but like many parts of communicable disease control that is due to closely-knit, informal networks and EU obligations rather than any stable, transparent, formal – or even identifiable – design.[18] While the three devolved systems are fairly clear, England gets along with sadly outdated guidance on the allocation of responsibilities for communicable disease control and a high-status quango (the Health Protection Agency) whose powers are unclear on an English as well as UK level. It should be no surprise that the English approach to intergovernmental coordination is equally lackadaisical. So long as there is no

16. Jeffery, C. and Palmer, R. 'Continental Affairs: Bringing the EU back in' in Trench, A. (ed.) (2007) *Devolution and Power in the United Kingdom*, Manchester University Press.
17. See (2008) Greer, S.L. *Organising for Europe: How the health systems of France, Germany, Spain and the UK engage with the European Union*, The Nuffield Trust (forthcoming).
18. Rowland, D. (2006) *Mapping Communicable Disease Control Administration in the UK: Between devolution and Europe,* The Nuffield Trust.

major breakdown, informal networks and conference calls between Chief and Deputy Chief Medical Officers have done the coordinating.

If there is a major crisis, it will be the responsibility of COBRA[19] and the Cabinet Office's Civil Contingencies Secretariat, and potentially involve the Civil Contingencies Act 2004. Neither bodes well for the autonomy of devolved governments, or for the coordination required if the UK Government is effectively to commandeer devolved resources. The World Health Organisation calls for 'command and control' in times of major outbreaks, but this supposes that the commanders have previous connections with and knowledge of the bureaucracies they should control.[20] Devolution does not guarantee that.

Communicable disease control is easy to forget precisely because it works. But it generally works because it is highly networked and bureaucratised, with work routinised and coordination long-established but informal. Devolution (including the newly announced Public Health etc (Scotland) Bill) and recent English health system reforms have broken up large parts of those networks and bureaucracies, so we do not know how good the coordination really is. And the stakes could be high. A major outbreak is not the time to subject neglected systems to a stress-test, as the 2001 Foot and Mouth disease outbreak showed. Moreover, the constitutional position of UK Government action could potentially be open to challenge if both it and the devolved administrations took maximal views of their powers under the existing law, with serious long-term legal consequences as well as short-term practical ones.

2.2.4 Contracts

Most of the giant contracts that govern the pay (and influence the management) of health service employees are UK-wide: the consultants' contract, the GMS (GP) contract, and Agenda for Change (covering non-medical NHS employees). The two doctors' contracts have also been responsible for a substantial amount of new expenditure. It is not hard to find devolved policy-makers who complain that these very expensive new contracts reflect problems of London and southeast England, and are inappropriate to their budgets, priorities and management strategies.

There is no legal reason to have a single UK-wide contract. The decision was, in large part, a failure of devolved nerve; no devolved administration wanted to take on the task of negotiating with the big health unions and run the risk that they would negotiate badly or that a separate English contract would price them out of key labour markets. But now

19. The civil contingencies committee that leads responses to national crises. The name is taken from its usual meeting place: Cabinet Office Briefing Room A.
20. World Health Organisation (2006) *Working Together for Health: The world health report 2006,* WHO.

there is increasing pressure on single contracts, both from devolved policy-makers and also from policy-makers who would prefer to see more regional pay in England. Scottish and Welsh policy-makers have told us that they would not, knowing what they know now, have delegated so much authority to the UK negotiators.

If UK-wide pay agreements start to break down that will have important implications, not least for where medical professionals choose to work or develop their careers. It is not clear that there has been enough thinking about the costs and benefits of such changes in the labour markets. Northern Ireland, Scotland and Wales all have higher percentages of public and health service employment than England, lower costs of living, and different fiscal pressures, so the consequences of a move to decentralise the contracts could be dramatic for workforces, budgets, and even their wider economies. Reflecting the potential risks, policy-makers in other areas have done the exact reverse; higher education policy-makers have tried to maintain a consistency of approach, partly to avoid disrupting the UK-wide labour market.[21] Changing pay structures without extensive coordination between the four governments could consequently embitter relations and create major policy and political problems.

It will also present problems for the professional unions that represent NHS workers. Public sector unions, quite rationally, negotiate with the level of government that determines their members' pay and conditions, and their internal organisation largely reflects that. If pay and conditions become the concern of the devolved administrations, then it is almost guaranteed to cause strains between London and the devolved offices of the big representative organisations.

2.2.5 Standards

There are two sources of pressure for shared health standards (for access, or for quality). Both are still speculative, but could create pressure for a standards police. One is the connection between standards of health quality and access, and the citizenship rights of the people of the UK. Prime Minister Gordon Brown has given many speeches that clearly identify 'the NHS' as a vehicle and exponent of 'Britishness'.[22] More recently he has suggested that there should be a 'constitution' for the NHS. Given that there are four NHS systems, there are a variety of ways the UK Government might start to try and rouse support for a statement of shared values in health. These standards could be benign and anodyne: a statement in general terms by the four governments that they agree on certain shared values of the NHS, including universal access free at the point of use. They could also be tougher and more specific. Conceivably, Brown's proposed 'NHS constitution'

21. Trench, A. (2008) *Higher Education and Devolution: A report for Universities UK*. Universities UK (forthcoming).
22. Greer, S.L. and Rowland, D. (eds) (2007) *Devolving Power, Diverging Values? The values of the United Kingdom's national health services*, The Nuffield Trust.

could be a vehicle for this, if adopted on a UK-wide rather than England-only basis. On the other hand, if it were clear that an NHS constitution were England-only, the result would be to make it clearer that the UK has four, not one, health services. And if it claimed to be a UK-wide NHS Constitution, but was based only on legislation for England, then the result would perpetuate confusion and could greatly irritate devolved leaders. But it might change the course of debates about standards and rights as well as the structure of devolution in health. In a worst-case scenario, Westminster could try to impose common standards, or make them specific enough to be a basis for litigation by individuals if breached, or both. Either (let alone both) would be a recipe for a major constitutional conflict. When the proposal for an NHS constitution was announced in May 2008, as part of the NHS Reform Bill that formed part of the UK Government's draft legislative programme for 2008/9, it transpired that what was proposed applied to England and Wales, but not Scotland or Northern Ireland.[23] Indeed, the Scottish Government had not been consulted about the UK proposal, and consultation with Wales had been late and sketchy (partly because the proposal itself was so sketchy).

In a best-case scenario, the governments could reverse their current tendency to produce *less* comparable data on most issues, and instead try to produce better data that citizens can compare. Comparable, identically collected data would be a boon for citizens and researchers alike – and might produce pressure on all four governments. As it is, the National Service Frameworks that establish best practice and standards for English health care are widely read across the UK, even if they are technically often only English.

The other is longer-term. The European Union's increasingly tough rules on patient mobility are creating pressures (rarely discussed in public) for EU rules on quality of health care. There has already been extensive EU-driven harmonisation of less salient areas such as blood and blood products for medicine, food safety and animal health. In the same way that a cross-border market in agricultural products led to demands for cross-border food regulation, a cross-border market in health care might be leading to demands for cross-border health services regulation. There are already EU declarations of shared health values, and it is not hard to imagine (or find) pressure to start to add detailed and legally-binding content to the current declarations that health should be high-quality, financially sustainable and universally accessible. Insofar as pressure for EU standards develops, it will expose the devolved administrations to the political vulnerability that all 'regions' face in the EU environment. By far the most effective way for Northern Ireland, Scotland and Wales to participate in an EU debate about standards would be if they had the UK Government with them – but that of course requires the UK Government's agreement, and that cannot be guaranteed.

23. Office of the Leader of the House of Commons (2008) *Preparing Britain for the Future: The Government's draft legislative programme 2008/9*. The Stationery Office.

2.2.6 Regulatory and quality organisations

The regulatory and quality organisations of the UK have particularly complex interactions with devolution. This is because the line between professional regulation – which is a reserved power – and health services policy, which is largely devolved, is not clear. The result is that NICE (the National Institute for Health and Clinical Excellence), the Healthcare Commission, the General Social Care Council and other organisations have ragged edges. Like the Health Protection Agency, they have different configurations of powers in different places. They must pay the fixed costs of understanding policy in different jurisdictions, even though England absorbs much of their time and energy. The benefits of exchanging good practice across the UK could well be outweighed by the administrative hassle of servicing more than one jurisdiction. But at the same time, breaking them up to fit with the borders of the four systems could diminish opportunities for learning and the higher standards that can come from comparisons. This produces one set of potential problems: the confused accountability and delicate legitimacy of UK organisations when working in devolved systems.

A second, and politically dangerous, set of problems comes from the development of devolved regulators and assessment organisations. Despite being poorly understood, these organisations are responsible for some of the most politically salient differences in health services. Few in politics, let alone the public, understand the relationship between NICE, the Scottish Medicines Group, and the All Wales Medicines Strategy Group – but those groups make decisions that are intensely interesting to pharmaceutical companies, the press, and patients.[24] At present, their liaison is of the sort we have discussed above – *ad hoc*, informal, and dependent on personal contacts and shared interests, not on any formal mechanisms for communication let alone adopting shared approaches. While it is wholly appropriate that each health service has its own regulators within its competencies, it is not at all clear that this is widely understood by the public at large. Nor is the accountability of UK-wide organisations always clear when they are working in devolved settings. NICE is a good example of this politically important confusion; see Box 1, overleaf.

With the passage of the 2007/8 Health and Social Care Bill, presently in Parliament, England will presently see many of its major health regulators merged into a single Office of Health and Adult Social Care – Ofcare. Initially introduced as part of the 2006 Budget as a cost-saving rationalisation, it will reshape the organisation of England's regulators by merging the Healthcare Commission with the Commission for Social Care Inspection and the Mental Health Act Commission into a single Care Quality Commission. This will have obvious

24. The *Daily Mail* appears to have been the first paper to lead with the headline "MEDICAL APARTHEID", on 20 October 2006. The story was, needless to say, about a medicine that had been approved for NHS use elsewhere in the UK – in this case in Scotland – but not in England.

knock-on effects for health and social care regulation across the UK, especially Wales (where the three bodies have had very different levels of activity); it affects 11 different regulatory bodies, most of them UK-wide but with ragged edges.[25] The new Care Quality Commission will still have responsibilities in Wales, but their actual content is not wholly clear.

Box 1. Areas in which NICE guidance applies

Tucked away on the NICE website[26] is a table setting out the following territorial resposibilities:

England
- clinical guidelines
- technology appraisals
- interventional procedures
- public health guidance

Wales
- clinical guidelines
- technology appraisals
- interventional procedures

Northern Ireland
- clinical guidelines – with advice on implementing in the context of the health service in Northern Ireland from the Department of Health, Social Services and Public Safety (DHSSPNI)
- technology appraisals – with advice on implementing in the context of the health service in Northern Ireland from the DHSSPNI
- interventional procedures

Scotland
- technology appraisals (with advice on implementing in the context of the health service in Scotland from *NHS Quality Improvement Scotland*)
- interventional procedures.

Little wonder that making sense of the overall pattern is so difficult.

25. The Stationery Office (2007). It is fundamentally justified by the commitments made in the 2005 and 2006 Budgets – as well as budgetary imperatives – but is loosely related to a broader 2007 White Paper on professional regulation. That paper is very clear about the need to recognise the distinctive powers, needs and strategies of the devolved administrations, but it is largely limited to assurances that the UK Government will work closely with the devolved administrations during legislation and implementation. Of course, that White Paper is also very clear that the UK Government would not be merging regulators. (*Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century*, Cm. 7013; para. 1.28.)
26. At www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/nice_and_the_nhs.jsp , accessed 31 March 2008.

2.2.7 Professional training and regulation

Professional education is essentially devolved along with the rest of education and health policy. But professional regulation is largely a reserved matter; the legal framework of professions and the regulatory Councils such as the General Medical Council (GMC), General Nursing Council and so on are reserved powers of Westminster (a few of the smaller ancillary professions are devolved). In part, this reflected pre-devolution worries about unspecified forms of 'fragmentation'. Those worries seem like historic curiosities now. The GMC itself is something of a historic legacy in its asymmetry and the prominent role of Scottish medicine, as seen in its combination of a devolved Scottish GMC and extensive Scottish participation in the UK GMC. There does not seem to be much pressure on UK professional regulation so far, but it could emerge over time. There are three reasons for this. First and most importantly, the devolved systems might flee from more episodes such as the simultaneous introduction of Modernising Medical Careers (a revolutionary change in training) and the MTAS system for allocating trainee doctor positions. The former was contentious and the latter a series of highly public IT failures. Wales retained responsibility for placing junior doctors and all three devolved administrations made it clear that they would keep their own counsel in planning for the future. They are reserving judgement on participation in future Department of Health-led training programmes, and it is by no means guaranteed that they will judge it safe to work with the DH in the future. Their confidence, or lack of confidence, in the UK Government is important because they are already clearly willing to drop out of at least parts of the UK-wide training system if it does not work to their satisfaction. Consider the comments made at a private Nuffield Trust seminar late in 2007: "There are two important things. One is that there be common training regimes. The other is that the English be exposed to good Scottish common sense!" Asked why there should be common training regimes, the answer was that it would ease Scotland's position as a net exporter of doctors within the UK labour market.

Second, new professions emerge constantly in health, and there is no guarantee that all four UK systems will want, as policy, to have the same professional demarcations and training requirements. A current example of this issue is the ongoing reform of nursing in Scotland, to create the new field of 'community health nursing'. Community health nursing will absorb the older fields of district nursing, public health nursing (health visiting and school nursing) and family health nursing.[27] Scotland will have a new profession not found elsewhere in the UK. Nurses from comparable disciplines in

27. Scottish Executive (2006) *Visible, Accessible and Integrated Care. Report of the Review of Nursing in the Community in Scotland*, Scottish Executive, 14 November. For further information, see www.scotland.gov.uk/Topics/Health/NHS-Scotland/nursing/review

England, Wales or Northern Ireland may have a difficult time finding jobs in Scotland. The merits of the change are not debated here, and the authors do not suggest that it would be good to choke off experimentation. It merely suggests that there are major changes afoot that will make the UK labour market for health care professionals more fragmented and shallower while undermining one small justification for the UK Union – and that these will both create political problems that require management.

Third, it is not stable for quality and clinical governance to be devolved while professional regulation is centralised. Efforts to improve quality increasingly involve changing the obligations of professionals. Quality issues rightly form part of the package of devolved functions, as part of the overall devolution of health systems, and each government's efforts diverge. This could cause problems: UK-wide regulation could become increasingly irrelevant as devolved agencies do more to govern professionals. Alternatively, the UK-wide regulators could start to look like they were blocking devolved innovation, with serious political hazards. In either case, the disruption of professional labour markets is more or less guaranteed. There is a simple example already – NHS Wales does not adopt the National Service Frameworks that structure medical practice in England. As a result, doctors educated and trained in Wales will have different understandings of good practice from those of potential employers in England.

It is not necessarily the end of the world if UK labour markets are disrupted. The global 'spot market' in health professionals shows that Indians, Filipinos and others are capable of working in the NHS, and EU professional regulation is based on the theory that German nurses are capable of working in the UK with little further preparation (even if others might question that). But there is little doubt that the broad and deep UK labour market has benefits for quality and specialisation, as health service employers can find people with specific interests while knowing that they will share a specific kind of training, professional socialisation and set of understandings. And, further, the decline of a UK labour market in such an area will start to open up much broader political questions about the purpose of the United Kingdom.

3. THE MANAGEMENT OF INTERGOVERNMENTAL RELATIONS

There is more and more friction as four increasingly different health and political systems rub against each other, and so there is more and more incentive to have political disputes that matter for health policy. What happens when there is a problem, whether a small one of trans-border cooperation or a big one of politically freighted argument about equity?

The UK's arrangements for managing intergovernmental relations need to be understood against both the constitutional and health policy backdrop. Devolved powers intersect and overlap with non-devolved ones in many ways, and the administrative structures for running the UK after devolution largely reflect that.

3.1 Formal arrangements for intergovernmental relations

3.1.1 The Joint Ministerial Committee and the Judicial Committee of the Privy Council

The procedures put in place in 1999 for the management of relations between the UK Government and devolved administrations in Scotland, Wales and Northern Ireland were set out in an overarching agreement, the Memorandum of Understanding.[28] Central to this was the Joint Ministerial Committee (JMC), representing all four governments. In its plenary form, consisting of heads of government, it would meet at least once a year to resolve any disputes that might arise, to discuss issues arising from devolved policies in

28. See HM Government (2001) *Memorandum of Understanding and Supplementary Agreements between the United Kingdom Government, Scottish Ministers, the Cabinet of the National Assembly for Wales and the Northern Ireland Executive Committee*, Cm 5240, The Stationery Office.

different parts of the UK, and the interaction of devolved and non-devolved policies. It would also generally keep relations between the four governments under review. However, the view has developed within government – and especially the UK Government – that its sole function was to resolve disputes, and none were referred to it between 1999 and 2002. It has not met since October 2002, despite the requirement to meet every year. This lack of engagement in intergovernmental matters at the highest level of government may have contributed to a sense in Whitehall that this was not a particularly important issue. It certainly means that there has been no forum which could actively manage intergovernmental relations.

Since it took office in May 2007, the SNP administration in Scotland has called for a revival of the plenary Joint Ministerial Committee (JMC) on several occasions. However, although the British–Irish Council (the 'Council of the Isles', set up under the 1998 Belfast Agreement) has met since then, the JMC has not – nor has Gordon Brown replied to, or even acknowledged, a letter sent to him by Alex Salmond in August 2007 asking for a meeting of the plenary JMC. The UK Government has slowly and reluctantly conceded the need to revive the JMC machinery, and during the spring of 2008 Paul Murphy (the new Secretary of State for Wales) has been visiting the devolved governments to discuss how it would work. There are suggestions, however, that the revived JMC would not be chaired by the UK Prime Minister, but by Jack Straw, Secretary of State for Justice and Lord Chancellor, as the Prime Minister's representative.

In addition to the 'plenary' JMC, 'functional' meetings have taken place in various specific areas. These have included health, poverty, the knowledge economy and Europe. Most of these areas (including health) had ceased to be active by the end of 2001, however. The European format remains active, and meets several times a year; indeed, it appears to have supplanted a parallel UK Cabinet committee. The only other areas in which devolved and UK ministers regularly meet are agriculture (about ten times a year, mainly to prepare EU business) and finance (twice a year).

As well as the JMC, arrangements were made as part of the devolution legislation for special procedures to enable the courts to consider legal issues. These were to be designated as 'devolution issues' and referred to the Judicial Committee of the Privy Council. In practice, the Judicial Committee has never dealt with litigation between devolved governments or legislatures and the UK institutions, and very seldom with the key issue of whether devolved legislation is within the legal powers of the body making it.[29] Most of the (few) cases they have considered have concerned human rights issues arising from criminal prosecutions in Scotland.

29. It has only considered devolved legislation twice, when human rights challenges were made to Scottish Parliament legislation affecting criminal justice.

3.1.2 The Memorandum of Understanding and bilateral concordats

The JMC (in its various formats) is established under the terms of the main intergovernmental agreement between the UK Government and devolved administrations, the catchily-titled *Memorandum of Understanding and Supplementary Agreements*.[30] This was first published in 1999, and was twice revised in the early years of devolution. The Supplementary Agreements relate to such matters as the handling of European Union business after devolution and financial assistance to industry as well as more technical matters like the collection and production of UK statistics. The Memorandum of Understanding is generally short on detail, though it does set out what it considers the basis of relations between the four governments – the 'four Cs' of communication, consultation, cooperation and confidentiality. The question has been whether these are in fact adequate on their own to manage relations when there are real political differences between governments – are they not the outcome of good relations rather than their foundation?

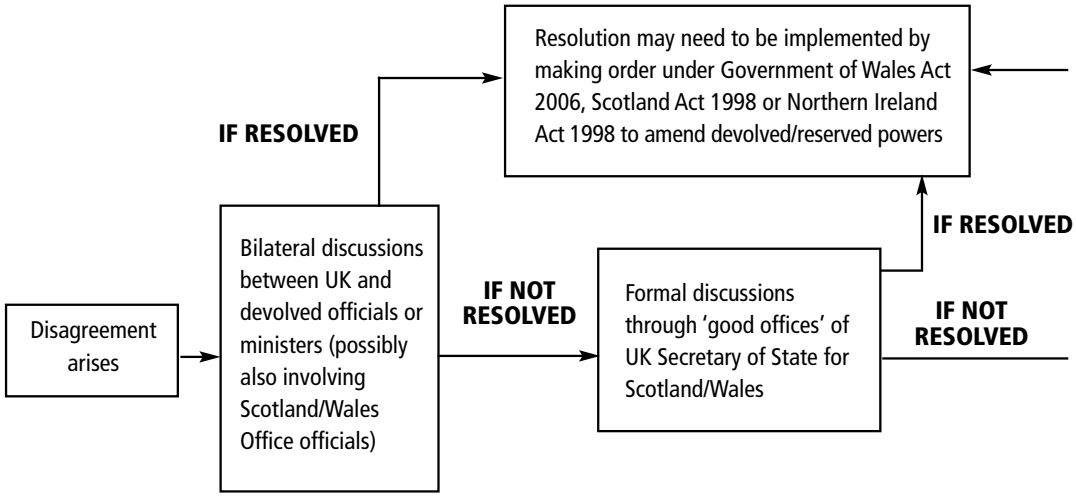
Following preparation of the Memorandum of Understanding (which was drafted in 1998/9), most Whitehall departments drafted what are known as 'bilateral concordats' with each devolved administration. Few of these are now readily available on departmental websites, and even when they are available they are very seldom used or referred to. For the most part, bilateral concordats tend to reiterate the general principles of good relations set out in the Memorandum of Understanding, but go little further than translating that into a specific departmental context. Most of the concordats have not been updated, but most UK departments and devolved administrations have been reorganised since they were drafted. Even these provisions of such concordats are no longer of very much practical use. Few concordats go beyond this – those between the Treasury and the devolved administrations do, and set out some rules for the exchange of information between the two, while that between the Home Office and the National Assembly for Wales identifies areas where the functions of the two intersect or overlap. For the most part, however, the most valuable contribution made by the bilateral concordats was when they were being drafted, when their production led Whitehall departments to think about the issues devolution would present. But that was a long time ago.

3.1.3 Understanding the disuse of the formal machinery

The disuse of the formal mechanisms for intergovernmental relations arises for a number of reasons. One was the view within government, particularly the UK Government, that they were not needed. As one interviewee once put it, "why have a meeting for the sake of having

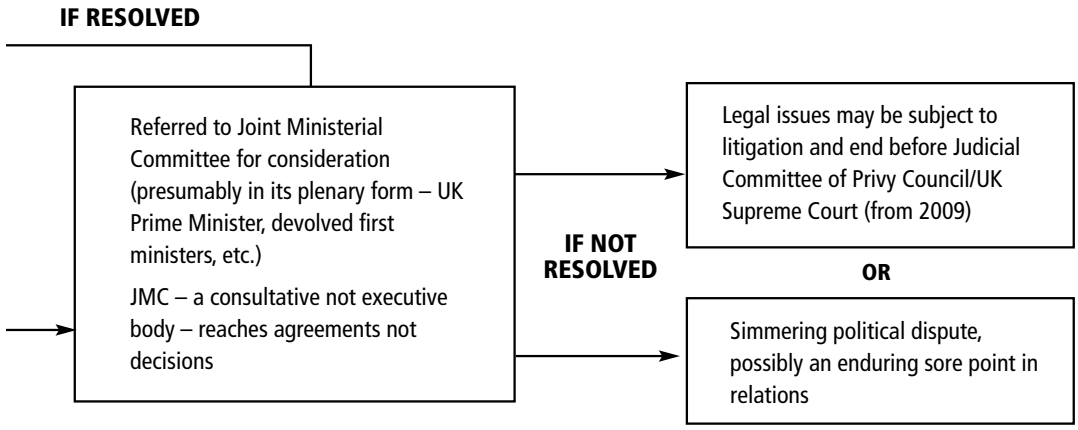
30. HM Government (2001) *Memorandum of Understanding and Supplementary Agreements between the United Kingdom Government, Scottish Ministers, the Cabinet of the National Assembly for Wales and the Northern Ireland Executive Committee*, Cm 5240, The Stationery Office.

Figure 1. Ways of resolving disputes between UK Government and devolved administrations



a meeting?" Because there was very substantial agreement between the devolved administrations and the UK Government (all three British administrations having Labour or Labour-dominated governments), they were felt to be superfluous. Labour's dominance of government did not lead to general agreement and consensus, but it created a climate in which there was no desire to pursue too forcefully or too publicly the disagreements that did arise. The shared electoral interest of the Labour Party – and the sense of mutual advantage arising from Labour holding office in the other level of government as well – meant that governments generally sought to reach agreements. Thus, when there were real disagreements (as about the Scottish decision to introduce free long-term care for the elderly, in 2001/2, or about what happened to the Attendance Allowance saved by the Department of Work and Pensions as a result, a few months later), the matters were resolved privately and behind the scenes. In the case of the overall policy, it was through a brutally frank discussion between the UK Work and Pensions and Health Secretaries, on the one hand, and the Scottish First Minister, on the other. In the case of the Attendance Allowance claim (which the Scottish Executive sought; it was then worth between £21 and £40 million a year), a claim was presented to the UK Government, considered, rejected, and not pursued to the JMC or Treasury ministers, as the procedures would have permitted.

The problem with this approach was that it assumed that the 'good times' of Labour dominance would continue, rather than using the good times to prepare for more difficult ones. Indeed, remarkably little thought was given in government to how to manage relations when there were real political differences between governments. This has been a major source of concern to academic commentators, and to the House of Lords



Notes:

1. *These stages reflect the expectations set out in the Memorandum of Understanding first drafted in 1999. They could be telescoped, or steps omitted, in practice.*
2. *There are numerous powers in each of the devolution Acts to amend that settlement to reflect agreed changes in the framework of devolution. Whether these need to be used or not depends on the nature of the agreement reached – but if political agreement can be reached, there is a huge amount of flexibility in the settlements.*
3. *Issues involving legal points may be referred to the courts (and may not be the subject of high levels of political contention – they may reflect technical issues on which a definitive legal judgment is sought by the parties). But the most problematic legal issues will be those where attempts to find a political resolution have failed, and that would imply consideration by the JMC.*
4. *These processes do **not** apply to financial disputes, which may be considered by the JMC but are determined by Treasury ministers and may be referred by a Secretary of State (not the devolved administration itself) to the UK Cabinet for a final decision.*

Constitution Committee in its 2003 report on *Devolution: Inter-institutional Relations in the United Kingdom*.[31] The view expressed clearly in the Constitution Committee report and by many academic commentators (including one of the authors of this report) is that relations should be conducted much more through the formal framework, and use of this stepped up (so that 'functional' meetings of ministers across the four governments would take place in more areas more regularly, and that these would be brought within the JMC framework). Governments – but with the UK Government clearly in the lead – have failed to act on these recommendations. Indeed, in some ways Whitehall seems to have forgotten about devolution; the July 2007 Green Paper on *The Governance of Britain* made scant, and superficial, reference to devolution questions.[32]

31. House of Lords Select Committee on the Constitution, Session 2002/03 2nd Report (2003) *Devolution: Interinstitutional Relations in the United Kingdom*, HL 28, The Stationery Office.
32. Ministry of Justice (2007) *The Governance of Britain*, Cm 7170, The Stationery Office.

3.2. The conduct of intergovernmental relations in practice

As noted above, it is remarkable how little the health sector comes to the attention of officials who make intergovernmental relations work, whether in the Scotland or Wales Offices in London or in the devolved administrations. When senior officials in those offices were asked in the summer or early autumn of 2007 what health issues they encountered, they looked puzzled. This is explicable largely because officials at working level have been able to resolve such issues between themselves so far. Given the greater political differences that exist between governments since May 2007, and the tensions to which this might give rise, the question is whether such issues will still be capable of being resolved at such a level. Academic research suggests that the present system is based on 'conditional autonomy', and that with the ending of Labour dominance of the various British governments this may cease to work so effectively in future.[33]

'Conditional autonomy' means that the autonomy that the devolved administrations enjoy in practice is based on very broad political understandings, and regular day-to-day cooperation between governments to achieve that. However, the broad understandings are essentially unarticulated and may not be viewed in the same way by all the actors involved (even common understandings can change, if the actors change); practical cooperation is patchy in practice and again can be withdrawn if political imperatives so dictate. Thus, the autonomy that the devolved institutions have in practice at present could find itself undermined without any change in the formal or legal framework of devolution, with serious effects both politically and for policy.

3.2.1 The roles of departmental ministers and officials, territorial Secretaries of State and officials at the centre of government

Instead, most practical intergovernmental relations are dealt with bilaterally, between a line department in Whitehall and officials dealing with the same policy area in the devolved administration. If matters become difficult, the Scotland or Wales Offices may become involved. Ministers are comparatively seldom involved, save for the Secretaries of State for Scotland and Wales, whose role in liaising with the First Minister of each country has been more demanding; even those posts became part-time in 2003.[34] (Northern Ireland is an exception, due to a tradition of greater administrative distinctiveness dating back to devolution to Stormont between 1922 and 1972 on the one hand, and the importance of the political role of the Secretary of State in relation to the peace process on the other.)

33. See Trench, A. (ed.) (2007) *Devolution and Power in the United Kingdom*, Manchester University Press.
34. Although Paul Murphy was re-appointed as Secretary of State for Wales in January 2008, it seems unlikely there is a full-time job to be done unless he greatly changes recent understandings of what the job entails.

Such contacts have proceeded principally at working level. Although there are some bilateral contacts between devolved and UK ministers concerned with particular policy areas, those have tended to be limited and *ad hoc*. Senior officials have played only a limited role, and contacts have tended to be driven by whatever was on the agenda of the day and the particular issues that need to be resolved to deal with that agenda. This has meant that legislation, or a crisis like Foot and Mouth disease outbreaks, have tended to initiate such contacts. They have not been sustained on a structured or routinised basis. Since 2001, with the winding-up of devolution or constitution teams in service departments, there has been an attempt to 'mainstream' knowledge of devolution across Whitehall so that all officials are equally aware of its importance and incorporate it into their day-to-day work. In reality, awareness is hugely patchy, and there has been a tendency for great variation in how departments, sections or branches, and even individuals approach devolution questions.

The absence of high-level ministerial and official attention means that it is easy for middle-ranking and junior officials to assume that this is of no real importance to their departments and their work, and to give such matters (which are constitutional in nature, after all) a low place in their list of priorities. Some departments (such as Trade and Industry or Environment, Transport and the Regions) were notorious in the early 2000s for being 'devolution-unfriendly'. This has changed since then (the list of devolution-unfriendly departments is now probably headed by DEFRA, with the new Department for Business, Enterprise and Regulatory Reform not far behind), but a high degree of variation remains.[35] Where does health stand? The lack of mentions of the Department of Health by devolved administration interviewees probably indicates not so much that it is neutral toward them, neither friendly nor unfriendly, but that the devolved administrations simply have very little to do with it at present. But the departmental culture here matters less than a simple axiom: the best guide to whether an individual official will be aware of the problems and sensitivities to which devolution gives rise remains whether she or he has dealt with similar issues previously.

Within the devolved administrations, approaches differ. In Scotland, two sets of officials coordinate matters – routine policy ones from within the Strategy and Ministerial Support directorate and constitutional ones from the Constitutional and Parliamentary Secretariat, both of which report to the First Minister. In Northern Ireland, coordination is handled in the Office of the First Minister and Deputy First Minister. In Wales, it is the responsibility of the Strategic Policy, Legislation and Communications department of the Welsh Assembly Government, and particularly of the Constitutional Affairs and Legislation

35. Interestingly, the Foreign and Commonwealth office has consistently been regarded as the most devolution-friendly of departments.

Management Unit. As in the UK Government, each of these central units plays a relatively limited role, and is particularly interested in legislative issues rather than 'normal' policy ones. No government appears to have a worked-through strategy for intergovernmental matters – and if they do, it is neither published nor readily apparent from their actions.

A further consequence of this informal approach to intergovernmental relations is that it gives a great deal of importance to internal organisation and arrangements within the UK Government. To a substantial degree, those arrangements become the framework of intergovernmental relations. For example, the most authoritative and detailed guide to how governments should deal with each other is not an intergovernmental agreement like the Memorandum of Understanding, but the 'Devolution Guidance Notes' now issued by the Ministry of Justice (and originally prepared by the Constitution Secretariat in the Cabinet Office in 1999/2000). The Cabinet Office's *Guide to Legislative Procedure* similarly gives relatively detailed guidance about when to consult the devolved administrations and about what.[36] However, none of this guidance helps resolve really difficult issues. And even if coordination within the UK Government improves, there is no guarantee that will not merely make for more effective pursuit of party advantage rather than better management of the diversity of politics, policy and government across the UK.

3.2.2 Legislative issues in practice: the Sewel convention and devolving legislative powers in Wales

The Sewel convention (see pages 19–20) has been widely used in practice. There were 37 such motions in the Scottish Parliament's second session (2003–7), while 81 Acts were passed. In that session, three Westminster health bills were given such consent. The first of these was what became the Health and Social Care (Community Health and Standards) Act 2003, which changed arrangements for recovery of NHS charges arising from personal injuries where compensation is paid, so as to maintain separate but parallel schemes in Scotland and in England and Wales. The second was the Health Protection Agency Act 2004, to extend powers of the Health Protection Agency to Scotland, principally for radiation protection issues but also infectious diseases more generally. The third was the Health Act 2006, for provisions about community pharmacists in Scotland, for changes to enforcing provisions of the Medicines Act 1968, and for some further changes to arrangements for recovering charges for NHS treatment from victims of personal injuries generally.

Since the SNP minority government came to power in May 2007, the number of legislative consent motions at Holyrood appears to have declined. Only three of the bills

36. See www.cabinetoffice.gov.uk/secretariats/economic_and_domestic/legislative_programme/guide.aspx

announced in the Westminster Queen's Speech of November 2007 have led to the tabling of such motions. One of these is the Health and Social Care Bill, so far as that relates to regulated healthcare professions which are within Holyrood's jurisdiction (such as operating department practitioners, dental nurses or dental technicians).

As yet, there have been no cases of legislative consent motions in the National Assembly for Wales. That is partly a result of the limited legislative powers the Assembly presently has, but also because of the way that the new arrangements are intended to work to confer legislative powers on the National Assembly. As discussed above, one is in the hands of the National Assembly – the Legislative Competence Order (LCO). The other is in the hands of Whitehall – the direct amendment of Schedule 5 to the Government of Wales Act 2006, to add particular 'matters' to the legislative powers the Assembly may exercise. Internal UK Government guidance, in the form of the Ministry of Justice's Devolution Guidance Note 9 on *Post-Devolution Primary Legislation Affecting Wales* (as reissued in June 2007)[37] provides for there to be consultation with the Welsh Assembly Government about all UK legislation affecting functions which are devolved in Wales or which change the executive or legislative powers of the Assembly Government or National Assembly, and for 'framework powers' to be used where both Whitehall and Assembly Government agree on this. This statement is weaker than an earlier indication given privately by one official involved, who suggested it might become normal for Westminster bills on a subject simply to devolve the corresponding 'matters' to the National Assembly.

More generally, the process of conferring legislative powers on the National Assembly is prone to difficulties. Some of these are to do with its inherent variability and inconsistency. Some arise from administrative issues – a reluctance on the part of ministers and officials in UK Government departments to extend the Assembly's legislative powers. Others arise from political factors, and in particular the continuing attempt by Welsh MPs at Westminster (mostly Labour, of course) to assert their power over the Assembly. This has yet to be seen in practice. However, clear warning signals have been sent (for example, through the Welsh Affairs Committee's consideration of the new procedures) that MPs might actively seek to block requests for LCOs, and might seek detailed information about a proposal (including even sight of the draft first Assembly Measure using the power) before agreeing to one.[38]

So far, the scope of devolved Welsh legislation in the health field has been limited, and relates only to redress of smaller claims against the health service without recourse to the courts (as enacted for England by the NHS Redress Act 2006).[39] There are apparently no

37. See www.dca.gov.uk/constitution/devolution/guidance.htm
38. See for example House of Commons (2005) *Welsh Affairs Committee Government White Paper: Better Governance for Wales, HC 551 Session 2005-06, First Report*, The Stationery Office.

immediate plans to devolve further legislative powers over health to the National Assembly in the immediate future, whether by action at Westminster (bills which add 'matters' to Schedule 5 to the 2006 Act) or at the Assembly's instigation (by seeking a legislative competence order or LCO). In any event, health remains devolved on the executive level. Given the scope of those powers and the other pressing health issues on the Assembly Government's agenda, it would appear that securing increased legislative powers is not a priority at present. It is notable that Health and Social Care Bill is not one of those that will contain framework legislative powers for the National Assembly.

The complexities that legislative consent motions pose are considerable. They raise serious technical issues, because of the complexity of modern legislation and the need to ensure the procedures of two different legislatures (and two different governments) mesh. To a degree, despite their widespread use, their constitutional complexities are not well understood either – what happens if Westminster legislates on devolved matters without consent? What happens practically (and perhaps legally) if a devolved legislature wishes to repeal or replace legislation passed at Westminster using the convention? While the existence of the convention has made life easier for many officials in the UK Government, there will need to be significant changes if its use becomes politically problematic. This is quite likely; the SNP has long been sceptical about the use of the convention, and since May 2007 it appears to be being invoked much less often than formerly.

3.3 The importance of political consensus, and its demise

As noted above, the working of devolution between 1999 and 2007 was largely explicable in terms of the 'conditional autonomy' of the devolved administrations, underpinned by the effects of Labour dominance of all governments. In 2007 that condition ceased to apply, with the election of an SNP minority government in Scotland, and the formation of a Labour/Plaid Cymru coalition in Wales. That suggests that the relative calm of recent years is unlikely to endure. As of March 2008, conflict had largely been about constitutional matters, with only some occasional spats about policy matters. Health has figured in these (for example, UK Government Minister Ben Bradshaw's sniping comments about health in Wales in February 2008), but has not been central; part of a generally more sober set of relations between Cardiff and London in health. Nonetheless, the difficulties have been sufficient to lead in February 2008 to the UK Government finally agreeing to revive the Joint Ministerial Committee, which met again on 25 June 2008, for the first time for eight years. That meeting was chaired by Jack Straw, not Gordon Brown,

39. The NHS Redress Act 2006 conferred 'framework powers' on the National Assembly, which were converted into a 'matter' by the National Assembly for Wales (Legislative Competence) (Conversion of Framework Powers) Order 2007, SI 2007 no. 910.

and was described as having been 'courteous and frank'.[40] There are also suggestions that there will be a new 'domestic' format, to meet at the level of service department ministers under the chairmanship of Paul Murphy. This would constitute a step, but only a partial step, in the direction of more formalised and systematic intergovernmental relations.

This is largely due to instructions to officials, at least in the Scottish Government, to continue their traditional openness and cooperative approach to their UK counterparts. If constitutional and political battles deepen, however, the incentives to maintain that sort of cooperation will diminish – and the need for more extensive and detailed routes of formalised cooperation will increase.

40. See 'Arbitration' move at UK summit', available at http://news.bbc.co.uk/1/hi/scotland/7472782.stm , accessed 25 June 2008.

4. POLICY RECOMMENDATIONS

From the above analysis, four main recommendations follow for improving intergovernmental relations as they impact on the health sector:

1. **Greater, and more systematic, coordination between governments.** The main mechanism for this needs to be two sets of meetings: at ministerial level, and at senior official level. Such meetings need not be frequent (twice a year would probably be adequate), but they do need to happen sufficiently frequently that each government is aware of the policies and concerns of the others, to make implementing the 'four Cs' a reality. The Joint Ministerial Committee (JMC) framework would be the best mechanism for this, as it would ensure a satisfactory level of publicity and importance was attached to the meetings, to encourage more junior staff at working level to take devolution issues into account throughout their work. If there is not enough health-related business to justify reviving the JMC (Health), then some sort of more overarching format (a 'JMC (domestic)' or 'JMC (policy)') might be appropriate. *What is important is the regularity of contact and the opportunity to raise health issues when they arise, more than a focus exclusively on health.*

2. Related to this, **the preparation of a more comprehensive intergovernmental agreement** setting out arrangements for the conduct of such relations in future. This would include the sorts of matters dealt with in the bilateral concordats between the Department of Health and Scottish Executive, National Assembly for Wales and Northern Ireland Executive, as well as matters set out in the Whitehall Devolution Guidance Notes, and matters relating to bilateral and four-way ministerial and official meetings. The process of agreeing the Memorandum of Understanding and bilateral concordats at an early stage in preparing devolution was valuable in easing the transition, even if the concordats have not seen much use subsequently. That process of preparation involved identifying and thinking through different connections between administrations and the possible tensions that might arise. *A similar exercise now (especially following the arrival of nationalist parties in government) would be useful.*

3. Ensuring **better awareness of devolution matters for Department of Health staff** and others in Whitehall. This applies particularly in those areas where there is a high level of staff turnover or where officials lack the traditional civil service background and training. Such staff are particularly in danger of overlooking devolution considerations. While more formalised and systematic management of relations will have a considerable impact, *there remains a need to improve general awareness of what devolution means, what complexities it adds to policy-making, and the political sensitivities it creates.* Ignorance is far less of a danger for the devolved administrations' officials because it is easier for Whitehall, and any individual Whitehall official, to ignore them than it is for them to ignore Whitehall.

4. Creating **formal responsibilities for administrative coordination between systems.** This could be part of the larger formalisation and revival of the JMC process. Problems arise because of simple neglect, whether in the case of cross-border payment disputes between two NHS organisations that allow these to escalate, or because the diffuse responsibility for public health in England has left devolved officials puzzled about whom they should call. This calls for a small step: making sure that somebody acts as a dedicated contact point for any given intergovernmental issue. It would, at a minimum, require that departments specify individuals who are responsible for intergovernmental relations and ensure they have the time and support needed for the task. *There should be a clear contact person in the Department of Health and each devolved department who is capable of understanding and sorting out day-to-day issues at a middle level of authority,* and the DH should make clear statements about which offices are responsible for coordination in public health (there is a general case for a clear government statement of how communicable disease control works in England, a case made by the House of Lords and ignored by the Government). Letting such issues fester has no advantages.

This might read as a mere call to neatness. The reader might ask what would trigger such a set of changes, given the UK's well-documented culture of muddling-through. The answer is that the UK's approach to intergovernmental relations is too unstable to last – and the international experience briefly reviewed in Section 1.4 shows that no other decentralised country has been able to avoid both conflict and the institutionalisation of conflict resolution. Indeed, the revival of the JMC in a 'domestic' format means that it has changed even during the last stages of drafting this report. So change would not come about through a desire for neatness. These measures would enable policy-makers to anticipate problems and respond, although it may be that intergovernmental problems from above or from below will force policy-makers to act in any event. Anticipating the problems now would minimise much of the argument and conflict other countries have seen and it can expect to see, and allow those involved consciously to shape a system that suits their needs rather see one arise in the disjointed, *ad hoc* way that is often accepted as normal in the UK.

Appendix 1. The Nuffield Trust devolution project: list of main publications

Greer, S.L. (2008) *Organising for Europe: How the health systems of France, Germany, Spain and the UK engage with the European Union* (forthcoming).

Greer, S.L. and Trench, A. (2008) *Health and Intergovernmental Relations in the Devolved United Kingdom.*

Jervis, P. (2008) *Devolution and Health.*

Greer, S.L. and Rowland, D. (eds) (2007) *Devolving Policy, Diverging Values? The values of the United Kingdom's national heath services.*

Greer, S.L. (2006) *Responding to Europe: Government, NHS and stakeholder responses to the EU health challenge.*

Rowland, D. (2006) *Mapping Communicable Disease Control Administration in the UK: Between devolution and Europe.*

Jervis, P. and Plowden, W. (2003) *The Impact of Political Devolution on The UK's Health Services: Final report of a project to monitor the impact of devolution on the United Kingdom's health services 1999–2002.*

Woods, K. and Carter, D. (2003) *Scotland's Health and Health Services. TSO.*

Greer, S.L. (2001) *Divergence and Devolution.*

Jervis, P. and Plowden, W. (2001) *Devolution and Health: Second annual report of a project to monitor the impact of devolution on the United Kingdom's health services.*

Jervis, P. and Plowden, W. (2000) *Devolution and Health: First annual report of a project to monitor the impact of devolution on the United Kingdom's health services.*

Monaghan, S., Davidson, J. and Bainton, D. (1999) *Freeing the Dragon: New opportunities to improve the health of the Welsh people.*

Hazell, R. and Jervis, P. (1998) *Devolution and Health.*

Unless otherwise stated, all publications are published by the Nuffield Trust. Most recent publications are available at www.nuffieldtrust.org.uk