The Constitution Unit

The Nuffield Trust

Devolution and Health

Final Report

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Devolution and Health

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Summary of Key Points

Two parallel agendas: devolution, and health service reform

1. This study explores the implications for the National Health Service, and the health services of Scotland, Wales and England, of political devolution to Scotland, Wales and the English Regions.

2. All three countries share a common need to improve their populations' health and address health inequalities. All three have geographical areas in which the health status of resident populations is poor, and in many cases the extent of such health inequalities has increased in recent years. Action is needed to tackle systematically all the key determinants of the populations' health.

3. Two separate processes of reform are running in parallel in the UK, the introduction of political devolution to Scotland, Wales and the English Regions, and reforms of the health services including the replacement of the 'internal market' introduced by the previous government. The changes in the health services have been developed within the existing system of administrative devolution to Scotland and Wales. It would be unreliable to use the current proposals for health service reform in Scotland and Wales to assess the potential for greater divergence in future.

The scope for greater divergence in Scotland and Wales

4. The traditional culture in Scotland and Wales is strongly 'communitarian'. Devolution is seen as a chance to reassert this culture, and the health service will provide a highly visible test of the ability to do this.

5. The core values and principles which underlie the NHS in England, Scotland and Wales are unlikely to be adversely affected by political devolution to Scotland and Wales. There is little evidence that Scotland and Wales will develop significantly different models of care from those used in England, or that the practices of the English NHS will be much influenced by developments in Wales and Scotland.

6. Even if the same general model of health care is in use in Scotland, Wales and England, there is scope for considerable innovation and experimentation in the different countries in organisation, management and service delivery. There is a need to ensure that learning from such experimentation continues to be shared across the UK's health services.

7. In the initial stages of preparation for devolution, the design of the devolution legislation was the main focus of attention. How Scotland and Wales might use their new freedoms to innovate in health policy or develop different models of governance or health service delivery received less attention.

8. Scotland and Wales face particular challenges in addressing the health agenda.

   - The block grant to each country calculated by the 'Barnett formula' delivers higher per capita health spending than is available to the English Regions. In the past, higher spending on health in Scotland has not produced better health outcomes. Although the Scottish Parliament and the Welsh Assembly will have the ability to vire within their block grants,

and the former will have the ability to raise a limited additional amount through taxation, both countries are likely to have to tackle their health agendas while facing major financial constraints.

- The Scottish Parliament and Welsh Assembly will have a crucial role in shaping their nations' response to the health agenda. A widely perceived danger is that they may wish to interfere in day to day issues of service delivery, subjecting the health services to increased audit and scrutiny, rather than exercising a strategic leadership role. The most important single factor which might lead to the development of the appropriate strategic role will be the quality of the politicians who will be attracted into the Assembly and Parliament.

- The professions exert a powerful influence on the health agenda. Professional bodies will seek to maintain conformity in standards of clinical practice, education and training, terms and conditions of service. This may act as a brake on new developments.

9. In responding to the health agenda, Scotland and Wales have some advantages over England:

   - Policy villages' in Scotland and Wales, with tight political and professional networks, can make for quicker and easier agreement over policy and strategy

   - Health gain policies should be easier to implement because the small scale in Scotland and Wales makes it easier to work across departmental boundaries.

10. To support the new post-devolution situation in the health services:

    - The health services in Scotland and Wales would benefit from strong 'health policy communities' to support the analysis and development of new policies and practices. There is a need to stimulate development of further policy capacity outside of government

    - Scotland and Wales have a strong desire to form direct links with international bodies such as the EU and the WHO. This cannot be realised; but UK-level international health policy will need to be better managed, to allow for better flows of information and consultation

    - The Department of Health will need to distinguish more clearly between its all-UK role and its responsibility for the health service in England.

The regional agenda in England

11. The English health service makes up around 85% of the UK total, and thus has a momentum and direction that are unlikely to be perturbed by whatever the other 15% does. There is unlikely to be significant pressure to reflect any Scottish or Welsh innovations in English practice.

12. At present, the NHS in England does not appear have a *regional* agenda. The English White and Green Papers imply a system of *national* policies and targets, with *local* initiatives to meet them.

13. However, there are forces in play which will demand from the English NHS a regional, rather than local, response, and therefore a degree of strategic flexibility by the NHS at regional level may be required. The drivers for such change are to be found in the Government's plans for regionalism in England, starting with Regional Development Agencies; and in the public health agenda, which will require more partnership working by the NHS at regional and local level.

14. The proposed English Regional Development Agencies are primarily concerned with economic development, and will be interested in the health status of their populations for its impact on competitiveness. Although health is not one of their core functions, public health is one of the non-core areas in which they will have major consultative and advisory roles. The RDAs are likely to see the NHS bodies in their regions as essential partners in their activites, both for the contributions that they can bring to improving the health of regional workforces, but also as major regional employers in their own right.

15. The NHS is likely to come under increasing pressure from the RDAs to engage more fully in the regional development agenda. Changing the geographical structure of the NHS Executive's Regional Offices to match that proposed for the RDAs would help facilitate cooperation.

16. It is not yet clear what scope there may need to be for a *strategic* role for the NHS at regional level which 'adds value' to health activities locally within the regions. However, it seems unlikely that the NHS could stand outside an increasingly dynamic regional level of policy development. The objectives of the public health Green Paper are likely to be furthered if the NHS is an active participant in the development of regional regeneration and economic development strategies.

17. in large systems, innovation is often at the periphery. In the past the Scottish and Welsh health services have been the source of valuable experimentation and learning for the English health service. The English health service has as much to lose if UK-wide professional networks fragment or atrophy as do those in Scotland and Wales. The 'new English NHS' needs to make sure it keeps learning, and remains open to examples from abroad.

Chapter One

Introduction: Purpose and scope of this report

1.1 This report has been commissioned by the Nuffield Trust to explore the issues arising for the UK National Health Service, and for the health services in Scotland, Wales and England, that may result from political devolution to Scotland and Wales. It focuses mainly on the prospects for policy divergence and experimentation in those two countries, drawing on interviews conducted in Scotland, Wales and England; official publications; and discussions at four seminars held to debate our interim conclusions. The implications for central government and for the NHS in England are considered briefly towards the end; but Northern Ireland receives only a brief mention. In the time available we were not able to look at other countries with more devolved health care systems, to assess what might be learnt for the devolution of health policy and management within the UK.

1.2 In undertaking the research, carried out from September 1997 to March 1998, we were examining the early stages of two big sets of changes which still have a long way to run. The new government elected in May 1997 was committed

- to reversing many of the reforms to the National Health Service of the previous Conservative government, particularly the 'internal market' and GP fundholding
- to introducing a greater measure of devolved government, through devolution to Scotland, Wales and - to a lesser extent - London and the English regions.

1.3 The initial interviews on which much of the report is based were carried out in September and October 1997, after the publication of the White Papers on devolution to Scotland and Wales, but before the publication of the health White Papers. The first draft of this report was circulated and discussed at a seminar held at the Nuffield Trust in London in December 1997. A revised version, reflecting the new health White Papers, was discussed at three regional seminars in February and March 1998. The first two seminars, held in Cardiff and Glasgow, focused on the implications of devolution for the Welsh and Scottish health services respectively. The third seminar in Leeds sought to investigate the implications, if any, of the changed health policy arrangements in Scotland and Wales for the health services in the English regions.

1.4 This final report is written with the added information provided by the English and Scottish Green Papers on public health. although the Welsh one is yet to appear. The constant process of updating

and rewriting has made us appreciate that this can only be a snapshot of a continuously evolving picture. The base line is likely to change yet again before the Scottish Parliament and Welsh Assembly are elected in 1999 and start to develop their own healthcare policies.

1.5 In carrying out the research, and in discussions of the first drafts of this paper, it has been stressed repeatedly to us that it is important to differentiate between the discussion of health and the discussion of healthcare. There is an understandable tendency to consider the implications of devolution in terms of the changes it implies to the organisation and management of the health services in the three countries. Certainly, issues of organisation and management of healthcare are prominent among people's concerns, responding to a period in which the Conservative government's reforms were widely unpopular particularly in Scotland and Wales. However, time and time again we were told that the opportunities for Scotland and Wales had to be seen in terms of improving their nations' *health*, which implies a wider agenda. The public health Green Papers are an initial response to these concerns. The majority of our short report is devoted to headline issues in healthcare policy and delivery: whether there will be significant divergence between the three countries, and in what ways; what will be the main drivers of change; and what are the constraints on change. We attempt a preliminary discussion of some of the wider issues about the health of the different nations, but a full treatment of this would be beyond the scope of our brief and of our resources.

1.6 In assembling this report we have had a difficult task. When we started the research, in Autumn 1997, the picture in some ways looked clearer than it does now. This was because the main focus at that time was on developing the mechanisms of devolution. Little had appeared on the policy agenda that would emerge in Scotland and Wales; but our initial soundings indicated that, where health policy was concerned, there were considerable pressures for change. It appeared at the time that these pressures were greater than may have been appreciated at the UK 'centre' in Whitehall.

1.7 The main reason for the desire for health policy change was ascribed to the more 'communitarian' nature of the societies in Wales and Scotland. Health, together with education, are seen as being major priorities for the new Parliament and Assembly, and a 'test-bed' for the exercise of their new powers. As we write now, in addition to the devolution legislation, we have had three White Papers on reform of the health services in Scotland, Wales and England and two public health Greeen Papers.

1.8 The health policies so far announced have been driven by a UK government committed to reversing particular initiatives taken by its predecessor. They are essentially health driven rather than devolution driven. The existing framework of administrative devolution does allow for differences of approach; and there are some differences in the proposals for Scotland and for Wales, but in the main these are differences of emphasis or differences at the margin. It remains to be seen whether, when the Scottish Parliament and Welsh Assembly come into being and assume responsibility for their countries' health policies, they will consider the changes introduced in the White Papers sufficient to reflect their national cultures and aspirations.

1.9 As we look further into the devolved future, we need to consider whether the general policies of the Scottish and Welsh governments are likely to cause greater divergence in their national policies for health and health care. At present it is too early to say. If the same political party wins power in the three countries many observers assume that there will not be much divergence. This judgement may be wrong, because it may assume more commonality between Labour in Scotland, Wales and England than actually exists, and it may under-estimate the political dynamic of devolution, which will force the devolved governments to demonstrate to their electorates that devolution makes a difference.

1.10 Currently, the English NHS appears to remain largely untouched by the health developments in Scotland and Wales - there appear to be relatively few 'cross-border' issues or supra-national issues which will result in change in England being driven by what happens elsewhere. There is little feeling that England needs to learn from elsewhere in the United Kingdom! Those issues that have been identified are mostly for the Department of Health, but these in the main concern the need to distinguish between its UK role and its English role. A different style of operating, and a different culture, may be needed.

1.11 In terms of the organisation and management of the NHS in England, the regional agenda appears to have been largely ignored until now. Indeed, the last years of the Conservative government produced greater centralisation of the NHS in England with the replacement of Regional Health Authorities by Regional Offices, which are outposts of the central NHS Executive. The policy of the present Secretary of State to 're-nationalise' the Health Service also has major overtones of centralisation. But there is also the public health agenda with its emphasis on local partnerships to improve health, and local and policy experiments such as 'health action zones'.

1.12 However, we believe that the devolution agenda, as it begins to run in England, does have implications for the English NHS. The English regional agenda will initially be driven by economic development and issues around competitiveness, but these will result in policies which have a public health component, or which will demand a response from the health services in the region. We believe therefore that the English NHS may face in future a much greater tension between centralisation and decentralisation. And as regional voices become stronger in England, there will be pressure to broaden the agenda from economic issues to wider concerns. To the regional populations, health issues are likely to be as important as they are to the Scots and Welsh, and regions are likely to want their health services to be partners in the devolved policy process. At present, there is little sign that the English NHS is ready for this challenge.

1.13 The key to the future will lie as much in the way the different departments work together as with the content of health policies per se. The 'concordats' to be drawn up to govern these processes of working together are of great importance; but equally important will be the trust and goodwill of the politicians, professionals and administrators who must make the new system work.

1.14 If by a 'National Health Service' is meant a commitment to a particular set of core values and principles, we see little prospect of radically different health services in Scotland, Wales and England. But if the discussion turns to matters of organisation and management there is room for much greater experimentation and divergence in the new devolved system. Learning across the whole of the UK from policy and management innovations will be important. Who will 'hold the ring' and encourage this to happen?

Chapter Two

The relationship between health and healthcare

Better health or better healthcare?

2.1 As we mentioned in the Introduction, in our discussions with health professionals, managers and politicians the crucial difference between a focus on healthcare and one on health was widely recognised. Improving the health of a population is about far more than how the health services are resourced or organised. Indeed, some would say that the 'National Health Services' in the three countries, as commonly understood, are predominantly 'ill health services' – that is they devote most of their attention to treating illness rather than preventing it.

Variations in health status; reasons and policy implications

2.2 There have been numerous studies which have documented the existence of inequalities in health and explored the reasons for it. The evidence collected shows strong gradients in health and mortality measures, with lower socio-economic groups exhibiting considerably enhanced levels of mortality and illness than higher groups

2.3 Health inequalities exist within Scotland and Wales, as well as between the two countries and England. Tackling such problem areas will be one of the major challenges for the Parliament and Assembly. If the Scottish Parliament and Welsh Assembly are to address the improvement of the health of their populations, they will need policies that tackle the 'wider determinants of health'. Thus nutrition and diet, housing conditions, employment or the lack of it, and education are among the major factors known to affect health status, with the quality of the health care services playing a minor role comparatively. That the health services cannot tackle unaided these wider determinants of health was recognised when the English 'Health of the Nation' White Paper, and its Scottish and Welsh counterparts, were published in 1991.

2.4 There are obvious implications of this for both the policy process, and also the design and management of the machinery of government in the three countries. We reserve discussion of these aspects until later in this report. We first need to review the point from which the three countries are starting out. They do not all start from the same position. There is already some diversity within the

NHS in respect of the health status of regional populations, levels of expenditure, governance arrangements and models of service delivery.

Health inequalities in Scotland, Wales and England

2.5 There are marked geographical differences in death rates found in the UK, with higher death rates in the North and Scotland compared with the south and east of the country. These regional differences cannot be accounted for by differences in the *social* class composition of the regional populations, because regional differences persist even after adjustments made for social class. In the more prosperous south-east, for example, people in *each* occupational category tend to do better than their counterparts elsewhere.

2.6 A 1986 study, using data from the early 1980s, showed a sharp north-south gradient, with standard mortality rates ranging from 79 for men and 81 for women in East Anglia to 123 for men and 124 for women in Scotland (figures averaged over all social classes, Great Britain average = 100)

Region	**SMR**
Scotland	M 123 F 124
North West	M 114 F 113
North	M 114 F 112
Yorkshire and Humberside	M 104 F 102
Wales	M 104 F 105
West Midlands	M 102 F 100
East Midlands	M 95 F 95
South East	M 89 F 90
South West	M 87 F 87
East Anglia	M 79 F 81

Source: Smith, A., Jacobson, B. and Whitehead, M. (Eds.), The Nation's Health : A Strategy for the 1990s, (King Edward's Hospital Fund for London), 1991, p111.

2.7 On this basis, it could be said that Wales' health was worse than most of England's, and Scotland's health significantly worse. Data from the 1997 Regional Trends survey shows differences persisting.

Mortality and morbidity rates in England, Scotland and Wales 1995

	Deaths per 1000	**Life expectation at birth**		**Age adjusted mortality rates**		**Limiting long standing illness**
		Men	Women	Circulatory disease	Cancer	
England	10.8	73.8	79.3	443	261	19
Wales	12.1	73.6	79.1	482	267	22
Scotland	11.8	71.5	77.6	547	304	20

Source: Regional Trends, 1997 Tables 7.1, 7.3 and 7.16.

2.8 The health of the Welsh is reported to have improved relatively over the past 40 years, but the differential with parts of England still exists. In the 1998 White Paper 'NHS Wales : Putting patients first' the difference is described in the following terms:

> "Health in Wales is poorer than in the UK as a whole and than in many other Western European countries. Life expectancy is about one year less than in England; the death rate from heart disease in Wales is about 18% higher, and the rates of cancer are about 10% higher".

2.9 In making comparisons of health status between the three countries, the presence of the Home Counties causes a major distorting effect. If the Home Counties are removed from the comparisons, in general terms the health profiles of the different parts of the UK are broadly similar. Those in the Home Counties enjoy a higher health status than elsewhere. But there are significant variations within regions, often between adjacent neighbourhoods.

2.10 These areas of deprivation and poor health status occur throughout the United Kingdom, and there can be marked variations between localities as small as electoral wards. These local variations are likely to reflect the differences in class composition of residential neighbourhoods. One of the

features reported in Scotland is the extreme variation in health status that can exist within a very small geographical area, where wards with some of the best health indicators can be found adjacent to wards with the worst. Wales contains areas – the former mining valleys – where health status is particularly poor. And in England too there are areas where health status is far below the average, largely although not entirely in inner city areas.

2.11 Many studies have examined deprivation and its impact on health status. Different methods have been used to measure deprivation, and among the indices available are ones developed by the (then) Department of the Environment in the context of urban policy, and the Scottish Development Department, the 'Jarman score' which has been used to classify 'underprivileged areas' in England and Wales, and the 'DepCat' scores that most Scottish Health Boards are using to assess inequalities in their own areas. This last measure shows that a much greater proportion of the English population is in the "affluent" groups (DepCat 1&2) and a greater proportion of the Scottish population is in the most deprived groups (DepCat 6&7). The regional differences in deprivation include a heavy concentration of severe deprivation in Glasgow.

Population living at different levels of deprivation: England and Wales and Scotland

DEPCAT	England and Wales %	Scotland %
1 Affluent	21.6	6.1
2	30.4	13.7
3	21.7	21.8
4	14.7	25.5
5	7.6	14.8
6	3.6	11.4
7 Deprived	1.0	6.8

Source: Carstairs, V. and Morris, R., Deprivation and Health in Scotland, (Aberdeen University Press), 1991, 2, p31

2.12 Regional variations in standardised mortality ratios vary between 80 and 150 within contiguous areas in Scotland. Of the worst 20 localities in Britain in terms of standardised mortality ratio for ages under 65 in 1990-92, eight were in Scotland and the rest in the north of England or London. The health status of the population in Wales has improved relatively over the last 40 years, and there are no Welsh localities in the bottom 20.

2.13 These regional variations in health status present a major challenge for the devolved assemblies, in particular in Scotland, and will provide an important measure of the success or failure of their health policies. How much freedom they will have to develop new policies and structures is explored in the next chapter.

Chapter Three

The Government's devolution proposals

Scotland and Wales

3.1 Scotland and Wales already enjoy a considerable degree of **administrative devolution.** Their health services are run by the Scottish Office and Welsh Office, not by the Department of Health in London. This has enabled Wales to develop independent initiatives on learning disabilities, breast cancer screening and continuing medical education; and Scotland and Wales have not implemented every policy diktat coming from London. Scotland developed its own version of *Health of the Nation*, and the Efficiency Index did not "go north". The Scottish Version of the Priorities and Planning Guidance has slightly different priorities from the English version. But so long as they remain linked to the government in London, Scottish and Welsh policies must remain broadly the same: the government's common ideology and the doctrine of collective responsibility require it.

3.2 This is what will change with **political devolution.** The Scottish Parliament and Welsh Assembly, both directly elected, will come under local democratic control and may owe little or no loyalty to London. The Scottish Parliament will have significant law making powers which will include:

- "health generally including overall responsibility for the National Health Service in Scotland and public and mental health; also the education and training of health professionals and the terms and conditions of service of NHS staff and general practitioners.
- science and research funding where supported through SHEFC and where it is undertaken in support of other devolved matters.
- vocational qualifications including the functions of the Scottish Qualifications Authority." (Chapter Two of the White Paper *Scotland's Parliament* Cm 3658 July 1997).

3.3 The matters which the Government proposes to reserve to Westminster include:

- "regulation of certain professions primarily where these are currently dealt with under UK statutes, including medical, dental, nursing and other health professions.

- certain other matters presently subject to UK or GB regulation or operation including the UK research councils, nuclear safety, the control and safety of medicines, reciprocal health agreements... . In addition a number of matters in the health sector, including abortion, human fertilisation and embryology, genetics, xeno-transplantation and vivisection will be reserved in view of the need for a common approach."

These reserved matters are set out in Heads 7 and 9 of Schedule 5 to the Scotland Bill which gives effect to the White Paper proposals.

3.4 Financially, the Scottish Parliament will have little room to increase **total** public expenditure. It will be dependent on block funding from London, and will inherit the same total budget as the Scottish Office (£14bn), with annual changes set by a population-based formula related to changes in spending in England (the 'Barnett Formula'). The Scottish Parliament will have power to vary the basic rate of income tax by up to 3%. However, even if it used these powers it would only raise around £450m of additional revenue, some 3% of the total Scottish budget. Thus if the Scottish Parliament wishes to increase significantly spending on health (or on any other prioirty it may decide) then it will have to do so largely by redistribution within the existing budget.

3.5 The Welsh Assembly will not have law making powers, nor will it have power to raise additional revenue. It will allocate the £7bn budget currently assigned to the Welsh Office, will set policies and standards for the public services in Wales, and make orders and regulation through secondary legislation, within the overall legislative framework laid down by Westminster. The Assembly will need to work in partnership with the Secretary of State, who will continue to be a member of the UK government, and who will seek to ensure that the needs of Wales are reflected in government decisions and in UK legislation. The White Paper *A Voice for Wales* (Cm 3718, July 1997) described the Assembly's responsibility for the National Health Service in the following terms:

"The Assembly will take over the Secretary of State's responsibilities for the NHS and for the health of people in Wales. It will be able to:

- decide the scale of financial resources for health from within its overall budget
- monitor the health of the Welsh population and respond with policies to promote health and tackle ill-health

- promote good practice in health services and hold NHS bodies in Wales to account for their performance
- canvass and act upon the views of patients, staff and carers on the quality of health services
- ensure that the NHS in Wales has an adequate work force of well-trained staff" (para 3.28).

These functions do not appear in the Government of Wales Bill, but will be included in the Order in Council which will transfer to the Assembly the functions of the Secretary of State (clause 22).

3.6 The Assembly will also be able to reform health authorities in Wales (clause 28). It will be able to transfer the functions of health authorities to itself, but not to local authorities. The Assembly will have the power to reform or restructure NHS Trusts, since this is already a power of the Secretary of State for Wales, and such powers will transfer to the Assembly. The White Paper went on to say "[the Assembly] will thus have the power to provide strategic leadership, for example, by playing a direct role in delivering all-Wales health services where appropriate, in partnership with the NHS, local authorities and others."

3.7 The White Paper then reserved matters to the centre:

> "So that the NHS in Wales continues to operate as part of a national health service, the Government will retain responsibility for national standards and arrangements for matters such as professional education and training, and the pay and terms and conditions of NHS staff and the self-employed contractor professions. The Assembly will be represented in the appropriate national forums, to ensure the interests of Wales are reflected in these areas" (Paras. 3.28-29).

These are matters which in Scotland will be devolved.

Regional Government in England

3.8 Plans for the possible development of regional government in England are much less far advanced, and are currently limited to a Bill in the first session to establish Regional Development Agencies which will be responsible for promoting inward investment, helping small businesses and co-ordinating regional economic development. If in time regional chambers or regional assemblies are

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Chapter Four

Health and healthcare policies : The scope for variation in Scotland and Wales

Governance arrangements for the health services

4.1 The governance arrangements for the health services in England, Scotland and Wales were broadly similar before the reforms proposed by the White Papers, and will remain so after the proposed changes. The main difference has been that in England there has been an NHS Policy Board as well as the NHS Executive; and England has eight regions whose directors sit on the NHS Executive, and who are the line managers and budget holders for the health authorities. The Policy Board and Executive were intended to distance Ministers from day to day management of the NHS: an aspiration which has largely failed. Scotland has its own Management Executive, and a separate Health Policy Unit. In Wales, the Director of the NHS Wales is regarded as responsible for the management of the Welsh Office Health Department, which has policy responsibilities, rather than for the NHS in Wales. In terms of accountability this has some important implications at the detailed level.

4.2 In all three countries the 'internal market' reforms of the Conservative government introduced a division of functions between health authorities and GP fund holders as purchasers of health services and NHS Trusts as service providers. The 1990 health service reforms epitomise a policy which Scotland and Wales almost certainly would not have adopted, had devolution been in place. The Scottish and Welsh White Papers have now set out their proposals for abolishing this policy, as has the English paper. The organisational arrangements for the 'new' NHS in each country are similar but not identical. Although the 'internal market' has been abolished, the separation of the 'commissioning' process, by which health care needs are assessed and health services are designed to meet them, and the provision of those services, is being maintained in all three countries..

4.3 All three countries propose revised organisational arrangements for involving general practitioners, and for dealing with those general practitioners who had became 'fundholders' under the previous Government's policies. GP fundholding in Scotland and Wales was never as popular as in England, and never reached the levels obtained there. This may be reflected in the slightly different approaches to its replacement. In all three countries fundholding will cease. In Wales, subject to the necessary

legislation, Local Health Groups will formally succeed fundholding from April 1999. In Scotland, too, the standard GP fundholding system will be brought to an end and replaced by Local Health Care Co-operatives. The same purpose is evident in the English White Paper, but the language is slightly more guarded. It speaks of the Government discussing 'with all concerned an orderly transition' from GP fundholding. The English future will contain two organisational models, 'Primary Care Groups' and new 'Primary Care Trusts'. There will be a degree of flexibility available in a given location over the organisational arrangements that replace fundholding. Subject to legislation, the English GP fundholding system will be wound up in 1999.

Service specification and the organisation of service delivery

4.4 Aside from the issue of general practice, in terms of service delivery the three countries start with the same basic set of institutions and assumptions. Acute, hospital based care is provided on a hierarchical basis, with most acute needs being met at the district general hospital, backed up by regional centres of excellence; and the gatekeepers to the system are the GPs, who are also the providers of primary care. The service deliverers are organised as 'NHS Trusts' with their own governance structure of Chairs and non-executive directors appointed by the respective Secretary of State. In most cases, NHS Trusts specialise in either secondary or primary care, although a small number provide both acute and community services. Both Scotland and Wales are heavily preoccupied with acute service rationalisation, but this currently seems to be more to do with eliminating surplus capacity in the acute sector and raising quality of care, rather than being inspired by a desire radically to reorganise care delivery, although plans for this do exist in some places.

4.5 The previous NHS reforms established in all three countries bodies which 'commissioned' or 'purchased' health care, variously termed Health Authorities or Health Boards. The new proposals involve revisions to the governance and accountability mechanisms of such bodies, propose some additional functions and establish new systems, but do not alter this fundamental structure. There are some variations in the way the commissioning role is likely to be discharged in future.

4.6 Across Britain as a whole the formal relationship with local government is one of separation, although in particular localities joint working and even joint commissioning of services has helped integrate provision of services across the health/social service boundary. The White Papers will strengthen this trend in various ways in each of the three countries. The objective of improving partnership working between the health service and other organisations, particularly local authorities,

features in all the White Papers.

4.7 One further point to be made on the governance arrangements is the extent to which professional and other intermediary bodies contribute to a 'loosely coupled system'. Key policy decisions on education, training and standards of conduct are granted by statute to the General Medical Council (GMC) and to bodies such as the Royal Colleges, whose influence runs far beyond their formal powers. All NHS Trusts are required to have a qualified medical director and nursing director on the board; and in Wales the role of the University of Wales College of Medicine in having representatives on every trust board is described as the "glue in the system". The power to make decisions is distributed across a number of levels and across the boundary between elected politicians and the leaders of the key professions within the NHS. This reflects the settlement established at the birth of the NHS, which has lasted over time because it suited both government and the professions for there to be a sharing of power and of responsibility: a buffer zone which allowed for a degree of professional and local autonomy, and for government some distancing from blame.

4.8 In a series of changes the previous government progressively created a tighter coupling, which in theory increased the Secretary of State's capacity to steer the NHS. In practice the reforms illustrated the limitations on governmental power. Except in a few limited areas, the internal market was still more myth than reality; and the professions have largely resisted attempts to downgrade their role in the system of governance at least at the 'whole system' level. There is evidence that professionals feel their influence has declined in the governance and management of Trusts. The White Papers seek to restore clinicial leadership of health service delivery at the NHS Trust level by stressing the importance of 'clinical governance', which is to feature strongly in the reformed health services.

4.9 In Wales, the activities in the early 1990s of the Welsh Planning Forum were strongly associated with strategic planning, the pursuit of health gain and a focus on primary care. A specific Welsh initiative has been the development of community-based facilities for learning disability. In Scotland the development of care in the community is considered to have lagged behind England and Wales. Articles in the medical press have suggested some readiness to experiment with the organisation of care delivery, but it is unclear exactly what organisational form this movement might take. Ideas floated include the integration of health and social service budgets, or the abolition of community trusts in favour of GP control of all primary and community services.

The scope for greater variation

4.10 The 'implementation gap' in the previous government's reforms is a salutary reminder when addressing the new powers which will be granted to Scotland and Wales. The Scottish Parliament will have the power, if it so wishes, to alter fundamentally the nature of the NHS in Scotland. It could alter the formal structure, currently based like the rest of Great Britain on the 1990 NHS and Community Care Act which created the internal market between purchasers and providers. It could establish a greater democratic input into health purchasing decisions, either by creating directly elected health authorities, or by linking health to local government. It could end the self-employed contractor status of GPs. And it could introduce a hypothecated health tax, by using its power to vary the basic rate of income tax, and channelling the proceeds into the NHS.

4.11 A Welsh Assembly will have more limited powers. It cannot repeal or amend the 1990 Act or transfer functions to local authorities; but it can change the number of health authorities and trusts,, and it can transfer functions to itself.

Policy objectives for the NHS

4.10 More important than restructuring or reorganisation, is the need in both countries for leadership and for a clear strategy and sense of direction (Warner, 1997). This is widely felt to have been lost with the recent reforms, and devolution provides an opportunity for refocusing and restating strategy and objectives. This may be easier said than done. Both Scotland and Wales see the extent of health inequalities within their borders as unacceptable and are likely to welcome the new public health agenda adopted by the Labour government (although action on inequalities has only just appeared as a priority in the Scottish Priorities and Planning Guidance document with the advent of the new government). But it throws up the same fundamental questions about the objectives and philosophy of healthcare which have bedevilled all three health services in defining their strategy and setting objectives for their purchasing authorities. Should policy be principally geared to

- the reduction of inequalities in public health status by improving the health of disadvantaged groups
- equity of access to healthcare facilities
- maximisation of the population's health

each of which may have different implications for the organisation and management of service

delivery?

4.11 There is also the problem of the dissonance between objectives and day to day preoccupations. Until now the climate has been relatively favourable for the development and implementation of clear strategies and objectives, because health services in Scotland and Wales have been planned and delivered with relatively little direct political interference. Both civil servants and professionals have had a relatively free hand: described by one interviewee as a "reign of professional ideas". Independent commentators said that civil servants in the Scottish Office and healthcare managers had done a robust and solid job of planning and managing care delivery. Others were critical of the too cosy relationships within the healthcare sector, implicitly recognising that, within the system of executive devolution which Scotland and Wales have had, there is a need to call decisions more effectively to account.

4.12 There is general agreement that in both countries the previous lack of direct political oversight will change dramatically. This could be to the detriment of effective strategic planning. Politicians may prove reluctant to grasp sensitive issues, particularly concerning acute service rationalisation; and they will always tend to be more interested in responding to short term pressures than long term planning. The Scottish Parliament and Welsh Assembly and their specialist committees will be much closer to Scottish Health Boards and Welsh Health Authorities than the Westminster Parliament is to most English Health Authorities; but this may simply provide more opportunities for shroud waving and gesture politics than rational debates. Healthcare may become even more of a political tool, rather than dealt with expertly by politicians prepared to lead on, rather than shy away from, difficult issues. This highlights the need for a genuinely independent health policy forum which can try to promote rational debate, even if the politicians play to the gallery.

The funding of health

4.13 The Barnett Formula delivers higher levels of funding in Scotland and Wales compared to England. The Formula was intended to achieve greater convergence over time, but has not done so. In 1995-96 identifiable general government expenditure per head on health and social services was as follows:

Territorial differences in health spending 1995-96

	England	Scotland	Wales	Northern Ireland	All UK
Health & personal social services	97	119	110	111	100
Total expenditure	96	119	112	132	

Source: HM Treasury, Public Expenditure Statistical Analyses 1996-97 (Table 7.6B), March 1996, Cm 3201.

4.14 Does the funding of the health services reflect the differences in health status? Both the Scots and the Welsh, in arguing for the maintenance of the Barnett formula would claim that the additional funding they receive is justified by the poorer health status of their populations and other factors which make the health services more costly to run. For example, a Scottish statistic quoted to us was that, although the Barnett formula delivers approximately 22% per capita more health spending than in England, the chance of dying of heart disease before the age of 65 is 30% higher in Scotland.

4.15 Such arguments could be used to infer that the Scottish health services are no better funded than those in England when the health of the respective populations is taken into account. But equally it could be argued that the Scots have done less to improve their nation's health, despite apparently more generous funding. We heard at least one argument that, in Wales, health was over-funded relative to England. It was claimed that, if Wales was an English region, with funding being based on health status, its health funding would be 103% of the UK average, whereas the Barnett formula delivers 110% of the all-UK figure. In other words, it could be argued that the Barnett formula is over-generous to Wales. Not surprisingly, our Welsh respondents strongly disputed such an interpretation.

4.16 Even if the higher spending in Scotland reflects the worse health status of its population, it cannot be justified on more general measures of need: Wales and Northern Ireland are significantly poorer in terms of GDP per capita (roughly 85 to Scotland's 98, if UK equals 100). It indicates that higher spending on health does not necessarily produce better outcomes: the higher levels of expenditure in Scotland antedate the Barnett Formula and go back at least 20 to 30 years (HM Treasury, 1979); indeed it was suggested that the roots go much further back to the strong investment in voluntary hospitals by public subscription, which created 'supply side' increased investment in the Scottish NHS prior to RAWP and SHARE. But in England the difference may in part be made up by private

medicine: 10% of the population in England have private medical insurance, compared with 5% in Scotland and 4% in Wales (General Household Survey, 1995-96).

4.17 When we started our investigations, the effect - and even the existence - of the Barnett formula was not widely known outside expert circles. The differential funding of public services in Scotland and Wales was not a matter of public comment and debate. Devolution will change that: as the devolution debate has unfolded, public comment on the formula has increased, and has featured in the UK national and English regional media. The UK government has held to the line that the formula is not for discussion or revision, but already pressures for change are coming from some of the developing regional lobbies in England, and from English MPs who perceive that their regions can make cases for additional funding that are at least as strong as those of Scotland and Wales.

4.18 In November 1997 MPs on the Treasury Select Committee initiated an inquiry into the operation of the Barnett Formula. Their conclusions, published in a short report on 22 December (House of Commons paper 341) can be summarised as follows:

- all parts of the UK are entitled to broadly the same level of public services, and expenditure should be allocated according to relative need
- the Barnett Formula is only a way of allocating **increments** in expenditure. It does not determine overall shares of public expenditure, nor does it reflect spending needs
- in 1995-96 public expenditure in Scotland was 19% and expenditure in Wales 12% above the UK average: spending in England was around 4% below the UK average
- it was time for a fresh needs assessment to show whether the Barnett Formula remains the appropriate method of allocating changes of expenditure to the four nations of the Union.

4.19 The Committee concluded their report as follows

> "We believe, however, that it is time to bring the needs assessment up to date; this would help to show whether the Barnett Formula remains the appropriate method of allocating annual expenditure increases (or savings) to the four nations of the Union. There may be good reasons why this formula should continue to be used in the future as it has for the last 20 years, but it is an argument that cannot finally be settled until it is clear that total expenditure, not just the increase, is still being allocated according to relative need. It is important that there should be maximum possible agreement on this in all parts of the UK".

Pressures of this kind may gather momentum as the devolution debate unfolds.

Chapter Five

Health policy and management processes: the Labour Government's agenda

The health White Papers and the public health Green Papers

5.1 The UK Labour Government was elected in May 1997 on a manifesto which committed it to 'a fundamental aim: to restore the National Health Service as a public service working co-operatively for patients, not a commercial business driven by competition' (Donald Dewar, in the Foreword to the Scottish White Paper). Central to this aim was the removal of the 'internal market' introduced by the previous Government. White Papers setting out the proposals for doing this in each of the three countries have been published, two in December 1997 (*The New NHS – Modern, Dependable* – describing reforms to the NHS in England and *Designed to Care – Renewing the National Health Service in Scotland* doing the same for Scotland.) The third, *NHS Wales: Putting Patients First*, containing the proposals for changes to NHS Wales, followed in January 1998.

5.2 All three papers do deal with the removal of the 'internal market', but all three go beyond this to propose wider changes to the way the NHS operates in each of the countries. In addition three consultative Green Papers set out proposals for strategies to bring about lasting improvements in the public's health. At the time of writing, two of these Green Papers have been published (*Our Healthier Nation: A Contract for Health* containing the proposals for England and *Working together for a healthier Scotlan*' containing those for Scotland). The Welsh public health Green Paper is yet to appear.

5.3 The three White Papers provide some early indications of the extent of divergence between the three Health Services. But it would be wrong to read too much into any early indications of similarity or difference. The Scottish and Welsh Papers have been developed in advance of the establishment of the Parliament and Assembly, and because of this both are preparing the ground for when these bodies take responsibility for their nations' health, and their health services. Both papers contain explicit recognition of this. They have been developed under the current system of administrative devolution, by a newly-elected UK Government with a strong mandate in all three countries amd with a leadership which emphasises strong central political control of policy development.

5.4 There are considerable similarities between all three papers. These include the values and principles underlying the reforms and many of the objectives and organisational reforms proposed. All three stress the need for improved partnership

- between different parts of the health services, replacing the competition encouraged by the internal market
- between the health services and other organisations, particularly local government
- between patients and the NHS.

Each paper proposes to end the internal market by replacing the annual contracting process between health authorities or boards and NHS Trusts, and each proposes to end GP fundholding. There are proposals to amend the governance processes to increase public accountability and transparency. There are also proposals to increase clinical efficiency and effectiveness through the use of evidence-based medicine. Improving the information base of the NHS, both for those working within it and for patients, forms part of each paper. All three papers claim to be adopting an evolutionary approach to change, retaining the best of the existing arrangements but eliminating the divisive and costly aspects of the internal market. A return to the centralised, 'command and control' arrangements prior to the Conservative Government's reforms is explicitly rejected; but much of the language is centralising in tone, and some of the proposals are centralising in substance.

5.5 As well as the similarities, there are some differences in terminology and differences in presentation and emphasis. While repeating the caveat that it might be wrong to read too much into these differences at this stage, the following paragraphs contain a brief review of some of the main proposals in the different White Papers.

Replacing the Internal Market - The Scottish proposals

5.6 The Scottish White Paper accepts that 'the strategic role and the service role are distinct functions.' In Scotland the formation of Health Improvement Programmes had already been announced in August 1997. These are developed by Health Boards, Trusts and General Practitioners working together and are designed to identify the 'mutually supportive objectives and action to be taken by each organisation over the coming years to improve the health of the population'. The Health Improvement Programmes will provide an overview of the health needs of the communities.

5.7 The key features of the revised organisational arrangements and responsibilities in Scotland are:

Health Boards will have the lead role in developing the Health Improvement Programme and will retain their existing responsibilities and gain a small number of new powers to ensure that local strategies can be implemented. Health Boards 'will need to liaise closely with local authorities'.

NHS Trusts will be re-focused on improving the quality to service to patients by giving clinicians and service users a bigger say in their management. The number of Trusts will be reduced, and Trusts will be of two main types, Acute Hospital Trusts and Primary Care Trusts.

Primary Care Trusts will 'give strong organisational form' to primary care. Typically they will be comprised of all community hospitals and mental health services as well as networks of general practices organised in Local Health Care Co-operatives. These Co-operatives replace the standard GP fundholding system which will be brought to an end.

5.8 Various other changes support these new arrangements. NHS Trust Chairmen become non-executive directors of Health Boards to help ensure that Boards establish a strategic agenda which can be achieved with the resources available locally. Trusts will be required to publish a set of clinical performance indicators which will be aggregated on an annual basis as part of the Annual Report of the NHS in Scotland. 'The Government see the development of these indicators as an important aspect of Trusts' accountability to the general public'. The setting up of a Scottish Health Technology Assessment Centre is announced, which will evaluate and provide advice to the NHS on the cost-effectiveness of all innovations in health care including new drugs. Also, a review of quality assurance approaches, where work is described as having been uncoordinated, will form part of the ongoing Acute Services Review.

5.9 A feature of the Scottish proposals is the creation of 'Joint Investment Funds', which will be established to encourage co-ordination of services at the interface between primary and secondary care. The White Paper comments

> "The development of an integrated delivery system requires GPs and their extended primary care teams to work with secondary care clinicians to design clinical services around the needs of their patients. The main purpose of this dialogue is to evaluate and test, within a clinical framework, those elements of care which are best provided in hospital and which elements can be delivered through the primary care team.

In order to support these improvements, each Health Board will establish a **Joint Investment Fund.** The objective is to increase responsiveness without attendant bureaucracy...".

Some of those we interviewed saw the creation of these funds as bringing about a very significant power shift from acute to primary care. This will be assisted by the likely creation of large Primary Care Trusts of almost equivalent size to the Acute Trusts, which is likely to result from the forthcoming reconfiguration of Trusts in most Health Board areas. The extent of the power shift to primary care was thought greater than that likely to occur in England and Wales, at least initially.

5.10 The Scottish arrangements will retain the Management Executive within the Scottish Office Department of Health as the 'Head Office' of the NHS in Scotland. In addition to supporting Minister, the Management Executive will have five key responsibilities:

- developing health service policy
- setting national strategic direction
- handling issues affecting several Health Boards
- managing the performance of the NHS
- promoting leadership.

5.11 The White Paper states that:

"The NHS in Scotland will be one of the main responsibilities of the Scottish Parliament. It will be for the Scottish Parliament to decide the details of its relationship with health bodies, including funding arrangements. Devolution provides an opportunity to build on the strengths of the NHS in Scotland, as well as on the Scottish tradition of community responsibility for those needing care. ...The new system outlined in this White Paper lays the foundations for the work of the Scottish Parliament in improving the health of the Scottish people now and for future generations".

The Scottish White Paper, however, does not devote as much space to the role of the Parliament as the Welsh White Paper devotes to a discussion of the Assembly's role in providing national leadership for the NHS in Wales.

Replacing the Internal Market - The Welsh Proposals

5.12 The Welsh White Paper is founded in the belief that reform of the NHS 'is about more than recreating mechanisms to replace the failed internal market. It is about reaffirming its founding principles and devising new responses to the challenges which face it.' It, too, adopts an incremental approach, by which the Government 'intends to remove those aspects of the internal market which have stood in the way of improving health gain and good patient care, while retaining what has worked'.

5.13 The Welsh proposals intend to

- Retain the separation of the commissioning process from the provision of services
- Promote further the involvement of GPs and other health care professionals in commissioning services for their patients
- Improve data about activity and cost
- Continue to develop better communications between primary and secondary care
- Retain the devolved operational management of NHS Trusts.

However, 'new and avoidable' problems have been created by the internal market including

- Inequalities in health and access to health services have been made worse
- Longer-term planning for NHS Wales has been particularly difficult with the fragmented structure of the internal market
- Resources have been diverted from patient care into bureaucracy.

5.14 To address these problems, the new vision for NHS Wales will stress collaboration and increase local responsiveness, removing obstacles to integrated care. The vision reinforces the strategic themes set for NHS Wales ten years ago but hampered by the internal market and 'lack of political conviction'. The themes are that

- The NHS should be health gain focused
- It should be people centred
- The service should be resource effective.

5.15 The structure to give effect to this vision will be composed of:

Health Authorities who will have new duties of partnership and improving the health of their residents, while retaining existing responsibilities for public health protection, health needs assessment, strategic planning and performance management, and relationships with newly-created Local Health Groups

NHS Trusts who will be charged with new responsibilities for co-operative action with health authorities, Local Health Groups, local authorities and others, and for improvements in service quality and relationships with patients and the public

Local Health Groups which will be based largely on local authority areas to enable more effective commissioning of local services. They will decide what services are needed locally and reflect the priorities of the people they serve in the services that are commissioned for them.

At the outset, Local Health Groups will be established as sub-committees of health authorities, but they will be responsible for commissioning local services and will be able to take decisions about resource use. Local Health Groups are likely to have coterminosity with unitary local authority boundaries. Local Health Groups will involve all GPs and other professionals in decisions about local services. Legislation will be brought forward to provide for the move from GP fundholding to Local Health Groups.

NHS Trusts will have a new statutory duty to contribute to improvements in health and the quality of health services. Trusts will be required to put in place new arrangements to engage local opinion, become more transparent and respond to user interests.

5.16 To support these new arrangements, the Welsh Office will be party to the establishment and management of a new National Institute for Clinical Excellence and Commission for Health Improvement. The latter will be a statutory body which will offer an independent guarantee that local systems are in place to monitor, assure and improve clinical quality and it will support local development of quality. The Commission will have the capacity to offer targeted support on request to local organisations facing specific clinical problems. The Commission will be able to intervene by invitation from NHS bodies or on the direction of the Assembly.

5.17 The role of the Assembly is discussed in some detail. The Assembly will take responsibility for the configuration and performance of NHS Wales and lead particular programmes of action. The

Assembly's policy-making and performance management roles and structures will be strengthened and new performance-related monitoring mechanisms will be developed. The Health Promotion Authority for Wales and some aspects of the Welsh Common Health Services Authority will be absorbed into the Assembly. In preparation for this the Welsh Office is to examine how its current Health Department, Health Professionals Group and Nursing Division, with HPAW and parts of WCHSA should be organised in future.

5.18 In readiness for the changes outlined in the White Paper the Welsh Office Health Department has reviewed the existing framework of strategic guidance and has concluded that change is needed to establish a clearer focus for authorities' strategic planning. It states that

> "NHS Wales cannot operate effectively without a firm, fair and forward-looking strategic framework. The Assembly will provide this following its creation".

But in the interim there is a

> "need for a clear and rational planning process that facilitates the development of a strategic framework for NHS Wales, which provides health and related targets, linked to practical guidance on what and how strategic change might be delivered, and engages key stakeholders in an on-going dialogue about how best to achieve desired change".

Consequently, the Welsh Office will lead the NHS in the production of a Corporate Plan for NHS Wales which will provide the basis for national activity as well as a focus for the performance of health authorities and their providers.

Replacing the Internal Market - The English Proposals

5.19 The English White Paper, *The New NHS – Modern, Dependable* was the first to be published. It has many similarities with the other two. The stated approach is to build on what has worked but discard what has failed. Thus the paper proposes a 'third way' of running the NHS, a system based on partnership and driven by performance. The 'divisive internal market system' of the 1990s will be discarded but there will be no return to the 'old centralised command and control system of the 1970s'.

5.20 The principles in the English paper are:

- to renew the NHS as a genuinely **national** service
- to make the delivery of healthcare against new national standards a matter of **local** responsibility
- to get the NHS to work in **partnership** with Local Authorities and others
- to drive **efficiency** through a more rigorous approach to performance
- to shift the focus onto quality of care so that **excellence** is guaranteed
- to rebuild **public confidence** in the NHS as a public service.

In keeping what has worked the separation between the planning of hospital care and its provision is retained. The reforms build on the important role of primary care in the NHS, and recognise the need to decentralise responsibility for operational management.

5.21 The English White Paper sets out three areas for action, **national standards and guidelines** for services and improvements, **local quality measures** to enable NHS staff to take responsibility for improving quality, and a **new organisation to address shortcomings.** Nationally there will be:

- new evidence-based **National Service Frameworks** to help ensure consistent access to services and quality of care across the country
- a new **National Institute for Clinical Excellence** to give a strong lead on clinical and cost-effectiveness, drawing up new guidelines and ensuring they reach all parts of the health service
- a new **Commission for Health Improvement** which will support and oversee the quality of clinical services at local level and tackle shortcomings. This will have powers to intervene where necessary.

The Welsh White Paper mentions collaboration in establishing the last two bodies.

5.22 Locally, the English NHS will have

- teams of local GPs and community nurses working together in new **Primary Care Groups** to shape services for patients
- explicit quality standards in local **service agreements** between Health Authorities, Primary Care Groups and NHS Trusts
- a new system of **clinical governance** in NHS Trusts and primary care to ensure that clinical standards are met, backed by a new **statutory duty** for quality in NHS Trusts.

These arrangements will require new roles and responsibilities. Health Authorities will become 'leaner bodies with stronger powers to improve the health of their residents and oversee the effectiveness of the NHS locally.' Over time these bodies will relinquish direct commissioning functions to Primary Care Groups. Working with local authorities, NHS Trusts and Primary Care Groups, the Health Authorities will take the lead in drawing up three-year Health Improvement Plans to provide the framework within which all local bodies will operate. These will be backed up by **a new duty of partnership.**

5.23 **Primary Care Groups** comprising all GPs in an area together with community nurses will take responsibility for commissioning services for local communities. They will replace existing commissioning and fundholding arrangements but will not affect the independent contractor status of GPs. The precise form of Primary Care groups will be flexible to reflect local circumstances. The Paper provides for a range of options for the form that Groups take. These start with supporting the Health Authority in commissioning care for its population through to becoming established as freestanding bodies accountable to the Health Authority for commissioning care and with added responsibility for their provision of community health services for their population. In this last case, they will become established as **Primary Care Trusts.** Primary Care Groups will be expected to begin at whatever point on the progression is appropriate and progress along it to assume fuller responsibilities.

5.24 The intention is that Primary Care Groups should develop around natural communities but also take account of the benefits of coterminosity with social services. Primary Care Groups will serve typically populations of around 100,000. Primary Care Trusts will be able to run community hospitals and other community services, but will not be expected to take responsibility for specialised mental health or learning disability services.

5.25 The Paper outlines changes to the arrangements for driving performance in the NHS. Among other things, these affect the Regional Offices, which are to have their responsibilities broadened to include quality assurance and the task of ensuring that partnership working is happening, in addition to financial oversight responsibilities. Regional Offices, with the Department of Health's Social Services Inspectorate, will jointly lead and monitor local action to strengthen partnership working across health and social care.

5.26 The Paper also details steps needed to involve staff at all levels in quality improvement, and develops

the concept of 'clinical governance' which all Trusts are to embrace. Clinical governance is described as an initiative

> "to assure and improve clinical standards at local level throughout the NHS. This includes action to ensure that risks are avoided, adverse events are rapidly detected, openly investigated and lessons learned, good practice is rapidly disseminated and systems are in place to ensure continuous improvements in clinical care."

Processes of clinical governance are not detailed, but one suggestion is the creation of a Board Sub-Committee led by a named senior consultant, nurse or other professional, as a result of which 'quality will quite literally be on the agenda of every NHS Trust board.'

5.27 Among other issues, the Paper outlines proposals for improved information services, including developments harnessing new Information Technology, to support the objectives of the new NHS. These services include improved information for service management and quality assurance purposes and also to allow patients and the public access to more and better information about the NHS, as part of the process of rebuilding public confidence.

Improving Health - the Public Health Green Papers

5.28 The English and Scottish Green Papers *Our Healthier Nation* and *Working together for a Healthier Scotland* begin to address the wider determinants of health, and take the debate beyond the organisation and management of healthcare services. The Foreword to the English paper describes it as setting out

> 'our proposals for concerted action by the Government as a whole in partnership with local organisations, to improve people's living conditions and health.'

The Scottish paper, in recognition of the need for all parts of government to contribute to the wider challenge of improving health, is signed by the Secretary of State and all the Scottish Office Ministers.

5.29 Both Green Papers propose to focus on particular challenges to health. The English Paper proposes to concentrate on four priority areas, setting clear targets for improvement in each,

- Heart disease and stroke

- Accidents
- Cancer
- Mental Health.

The priority areas are selected

> 'because they are significant causes of premature death and poor health, there are marked inequalities in who suffers from them, there is much that can be done to prevent them or to treat them more effectively and because they are real causes of public concern.'

Central to the English Green Paper is the concept of the 'Contract for Health' which sets out the mutual responsibilities of central government, local government and the public for improving health

> 'in those areas where we can make most progress towards our overall aims of reducing the number of early deaths, increasing the length of our healthy lives and tackling inequalities in health'.

5.30 The Scottish Green Paper suggests that health outcome targets should be drawn from five health priority areas

- CHD and stroke
- Cancer
- Teenage pregnancies
- Dental and oral health
- Accidents

It also proposes the setting of targets in rerlation to priority lifestyle topics of

- Smoking
- Alcohol misuse
- Eating for health
- Physical activity

The Scottish approach is to consult before setting targets on the priority health topics to be covered, the targets which might be set and the period which should be covered by the target.

5.31 The need for the health services to work in partnership with other 'stakeholders' features strongly in both Green Papers. The English Paper covers in depth the concept of local **Health Improvement Programmes**, which will be 'vehicles for making a major and sustained impact on the health problems of every locality in the country', and **Health Action Zones**. These are pilot schemes to 'provide a framework for the NHS, Local Authorities and other partners to work together to achieve progress in addressing the causes of ill health and reducing health inequalities'. The Scottish Paper does not have an equivalent to the Health Action Zones, but comments:

> 'The task of building a healthier Scotland is not for the Health Service alone. The National Health Service has the lead role in forming strong partnerships with local authorities, voluntary organisations and the private sector which are essential for success.'

Other changes pre-devolution

5.32 The White Papers and Green Papers, if translated into action, will produce significant changes in each of the three Health Services. But the new Labour Government is introducing other changes and, particularly in Scotland and Wales, these have to be considered alongside the proposals discussed above. Thus in Wales a major restructuring of Trusts is under way, which will radically reduce the number of Trusts. The reconstructuring will come into effect before the Welsh Assembly is in place. Currently no change is planned to the number of Health Authorities (the number of which was reduced relatively recently). In Scotland too Trust reconfiguration and merger is being pursued actively. The Scottish Parliament and Welsh Assembly will be able to re-visit these issues, if they so wish. The civil servants and health service managers involved are attempting to avoid a period of 'planning blight' when no changes are made because of the imminent arrival of the new governance structures, but at the same time hope the Parliament and Assembly will resist the temptation to embark immediately on further reorganisation. It remains to be seen what will happen.

Chapter Six

Implications for the 'UK centre'

6.1 The previous chapter explored the scope for greater variation in Scotland and Wales as a result of devolution. This chapter reverses the focus and looks at the impact of these changes on the centre. What will be the impact on the NHS in England? What role will be left post-devolution for the Department of Health in London, and for the Westminster Parliament? What will be the role of the EU?

6.2 For the Department of Health in formal terms relatively little will change. In terms of what the public understand by the NHS (primary healthcare and hospitals) the Department of Health is already the Department of Health for England only. The Civil Service Yearbook describes its current functions as follows: "The Department of Health is responsible for promoting and protecting the health of the nation, providing a National Health Service *in England* and social care, including oversight of personal social services provided by local authorities *in England*" (italics added). It then goes on to describe its international functions and industrial sponsorship role: "The Department represents UK health policy interests in the European Union and through relevant international organisations, including the World Health Organisation, and supports UK-based healthcare and pharmaceutical industries".

6.3 These matters will not change post-devolution. In international fora the UK will continue to be represented by the UK government, and not by the devolved governments in Scotland and Wales. At the domestic level the Department of Health will continue to be responsible for healthcare only in England, and for the NHS Policy Board and NHS Executive in England: there are separate executives and directorates in Scotland, Wales and Northern Ireland. What is administratively devolved now in executive and policy terms to Scotland and Wales will remain devolved, but will be subject to tighter democratic scrutiny in Edinburgh and Cardiff. What is administratively retained at the centre in London will remain at the centre and will be subject to scrutiny through the traditional mechanism of ministerial accountability to the Westminster Parliament.

6.4 The Department of Health will continue to be responsible for a mix of England-only functions and others where it has a wider role within the UK. Examples of the former are: NHS resource

allocation, monitoring NHS performance and health promotion. As well as international issues, the latter group of functions is likely after devolution to include, as now, abortion and human fertilisation and embryology; the control and safety of medicines and the regulation of the main health professions. It is likely that the English and UK roles will need to be distinguished more clearly post-devolution. We return to this point below.

What will remain 'national' in the NHS?

6.5 This question needs to be answered not merely in functional and bureaucratic terms, but in broader conceptual terms; and in terms of public perception and symbolism. In conceptual terms certain fundamentals will remain national. The NHS will continue to be nationally funded through an all-UK tax, income tax, raised by central government and distributed by the Treasury. So long as the Barnett formula continues, annual adjustments in spending will technically be determined by changes in English spending; although with England making up 85% of the whole, the UK government will effectively be deciding what proportion of the national finances to spend on health on an all-UK basis. But the devolved governments will be free to vire within their total budgets (e.g. between education and health, or health and housing); and the Scots will be free to raise up to 3% additional revenue by raising the rate of income tax.

6.6 In practice the room for major policy divergence will be limited: the Barnett formula cannot cope with major policy differences between England and the rest of the UK. The objective of devolution is to enable the devolved governments to pursue different policies; and the financial arrangements need to make it possible for this to happen in practice. But there will be problems in applying the Barnett formula if policy divergence leads to the English public expenditure analogue disappearing or ceasing to be broadly equivalent. Suppose that a future government in London decides to cut income tax, introduce tax incentives for private health insurance and reduce spending on the NHS. Under the Barnett formula this would lead automatically to a proportionate cut in the block grant for Scotland and for Wales; but they might want to retain spending on the NHS. There will have to be mechanisms in place to cope with differences between concepts of the public sector in England and the rest of the UK. This may require a fresh needs assessment, as recommended by the Treasury Select Committee, which would need to be regularly updated; or giving the devolved assemblies more scope to determine their own level of resourcing through local taxation.

6.7 In one respect devolution may make the NHS more 'national', if it brings about greater convergence

rather than divergence of public expenditure on health between England, Scotland and Wales. The Barnett formula was intended to achieve greater convergence over time, but has not done so (see chapter four). The Treasury Select Committee is to enquire into the different levels of territorial expenditure, which will become more exposed post-devolution. Given Scotland's relative prosperity, it is unlikely that the generous levels of funding in the Scottish block can be sustained. Scotland may be forced to reduce its generous levels of spending on health; even use of its tax varying power might not go very far to make up the difference.

Equity

6.8 Another fundamental is the concept of equity, which leads citizens throughout the UK to expect the same basic levels of public service. This is reinforced by the national media, which in the UK is particularly strong at national level; and further reinforced by performance measurement and national standards, which will be more vigorously pursued under the health White Papers. In the case of the NHS equity is understood to mean equality of access; but in different parts of the country it may no longer deliver equality of access to the same basket of free health goods. Tighter rationing applied at regional level may lead to a growing number of services (e.g. infertility treatment) being charged for in some parts of the country but not others. At present the regional disparities (including between the English regions) are not sufficiently great to provoke serious protest; but if they became greater, and better publicised, it may in time put pressure on the willingness of citizens to cross-subsidise those parts of the country where NHS services are more generously provided. Alternatively the UK government may come under pressure as the main funder to define the basic level of service provision through a charter of social and economic rights, or through more national standards, patients' charters etc.

The constraints on diversity

6.9 The NHS will also remain 'national' because of political and professional factors. The political constraint is solidarity between governments of the same party, so long as Labour rules in London, Edinburgh and Cardiff (although there may turn out to be little solidarity between New Labour in London and Old Labour in Scotland and Wales; and in Scotland Labour may need to rule in coalition). The professional constraint lies in medical and healthcare professions which are unified in England and Wales, and even when technically separate in Scotland observe the same training,

professional techniques and professional standards. Some health professionals in fields like public health and epidemiology will be keen to do things differently: to reduce health inequalities, and to break down the health/social care boundaries. But other health professionals and clinicians may represent powerful obstacles to change. There will be concern to preserve common standards of education and training; of registration and professional discipline; common terms and conditions of service, and of mobility between the three nations; and common approaches to the treatment of patients. Clinicians may vote with their feet against unwelcome changes; and other pressures such as evidence based medicine, and greater dissemination of guidelines on clinical effectiveness and cost effectiveness, will tend to reinforce a converging rather than diverging approach.

6.10 Regulation through the NHS Ombudsman and through audit will remain in common as between England and Wales, but may alter in Scotland. The Welsh devolution White Paper retains the Parliamentary Ombudsman to investigate complaints in Wales, but is silent about his function as NHS Commissioner; and it specifically preserves the role of the Audit Commission in relation to NHS bodies in Wales (para. 4.37). Audit promotes convergence rather than diversity. In Scotland audit will be by the Accounts Commission; and on complaints the devolution White Paper says "For complaints about the handling of devolved matters, there will be similar arrangements [to the Parliamentary Ombudsman] for Scotland, based as closely as possible on the UK Ombudsman legislation".

The role of the Westminster Parliament

6.11 At Westminster little will change, save that Scottish Ministers will largely disappear, as will the Scottish Grand, Select and Standing Committees. The Select Committee on Health will focus mainly on health issues in England; although it may continue to inquire into the Department of Health's all-UK functions. Scrutiny of legislative and other proposals from the EC will continue to fall mainly to the Select Committee on European Legislation in the House of Commons and the European Communities Committee in the House of Lords. Given the tight timescales often involved, and the lead role for UK ministers, it will be difficult to insert a strong role for the devolved assemblies except in terms of retrospective scrutiny, and wider thematic inquiries of the kind conducted by the European Committee in the House of Lords.

Health and the European Union

6.12 Expectations are running high in Scotland and Wales that devolution will give them a stronger voice in Europe. It is one of the arguments advanced for devolution; and the belief has been allowed to develop that Scotland and Wales might be separately represented in the Council of Ministers. On the rare occasions when that might happen it will only be at the invitation of the UK government. The member state will continue to be the UK; and Scotland and Wales will be represented only through the UK delegation. The Scottish devolution White Paper is firm and clear on this point:

> "The role of Scottish Ministers and officials will be to support and advance a single UK negotiating line which they have played a part in developing. The emphasis in negotiations has to be on working as a UK team; and the UK lead minister will retain overall responsibility for the negotiations ..." (para. 5.6).

6.13 This will not prevent Scotland and Wales forming closer links with the Commission, building on the influence they already have through their listening posts in Brussels (Scotland Europa and the Wales European Centre) and through their membership of the Committee of the Regions. But it will be an increase in influence in lobbying power rather than formal political power; and in an area where the EU's impact so far has been limited.

6.14 Many aspects of European Union activity have an impact on health, although the Union does not have a comprehensive health policy. The 1991 Treaty on European Union (the Maastricht Treaty) gave the Union a new competence in public health. This was achieved through two Articles, 3(o) and 129. Article 3(o) stipulates that the Community should contribute to the attainment of a high level of health protection while Article 129 identifies two areas for Community action, disease prevention and health protection.

6.15 There are three means available for the achievement of these objectives, research, health information and education, and the incorporation of health protection requirements into the Community's other policies. However, harmonisation of the laws and regulations of the Member States is specifically excluded. The 1991 Treaty also introduced the principle of subsidiarity. As set out in Article 3(b) this means that the Community will act only where it has exclusive competence or, where it shares competence with Member States, only where it can be more successful in achieving a particular

objective than can an individual Member State.

6.16 Since, initially the EU developed as an economic entity, health issues have tended to be of relatively low priority unless they are related to the needs of the Single Market. Nevertheless, these needs already cover product safety, health and safety at work, pharmaceuticals and medical devices, and the free movement of professionals. Mossialos and McKee (1997) list as areas in which European policies have had, or could have, an impact cross-frontier health care, the Working Time Directive, issues such as the BSE outbreak in the UK, tobacco advertising, medicines regulation, pharmaceutical pricing, the health insurance market, and developments in telemedicine and information technology.

6.17 The impact of the EU will continue to be patchy, because Member States are unlikely to agree to an extension of the Community's competence in the health field. The creation of a Directorate General for Health has been advocated since the 1970s but without success. Health is currently scattered through a number of different DGs and programmes of the EC, and without reorganisation which brought health issues together and gave them a critical mass and focus it is unlikely that the Commission can develop a coherent strategy to address public health issues. It is also unlikely that this can be achieved without revision of Article 129, which was proposed by the Commission in the run up to the Amsterdam Treaty but heavily watered down in the eventual settlement. The current institutional and legal backdrop does not provide a favourable basis for the development of a coherent EU public health framework.

6.18 The main European impact to date on health policy has been through the single market and allowing professionals to practise throughout the EC. Scotland and Wales are more Europhile than England and might want to accede more readily to further harmonisation; and possibly to encourage the EU to develop its limited area of competence in public health, as set out in the Articles of the Maastricht Treaty mentioned above. Health professionals have been calling for a more integrated approach; but it is less politically appealing, and the EC's public health unit does not have the resources to develop such an approach. However, even without the development of a comprehensive European Union health policy, it is clear that there will be an increasing need for health policy makers to take account of the European dimension when making decisions about national health policies. In the new context of health policy formulation in the UK, this need will be felt as strongly in policy circles in Scotland, Wales and Northern Ireland as it is in London.

6.19 It is a recognised tactic in other policy areas for regions to outflank member states by forging alliances direct with the Commission. In terms of gaining extra leverage against London on health policy issues, however, in the short term Scotland and Wales will not find the Commission to be a powerful partner.

Chapter Seven

Findings from the field: Making devolution work

The views from Scotland, Wales and the 'centre'

7.1 This section summarises the views of the people we interviewed, mainly in Scotland and Wales but also from London-based and English regional organisations, about what would be required to make devolution work. They were drawn from government (central and local), the Scottish, Welsh and English health services (including both health professionals and managers), academics and other members of the 'policy formation/influencing' communities. The interviews were conducted mostly after the publication of the Government's devolution proposals, but before the publication of the health White Papers.

7.2 In Scotland and Wales, 'making devolution in health work' was envisaged as much as a political process as it was a professional/medical one. It was associated with concepts of 'taking ownership' for the national health systems of Scotland and Wales, and producing something that fitted the culture, traditions and aspirations of the country. Despite the fact that devolution brings few new freedoms, for these respondents it was expected to make a difference:

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

7.3 A somewhat different view came from the interviews we conducted in London, or with people in 'London-facing' roles. The aims of raising health status and addressing inequalities were common between this group and our respondents in Scotland and Wales, but there was a strong undercurrent in these views that such objectives were best achieved by maintaining a unified 'National Health Service', and thus of resisting any divergence of the health systems in Scotland and Wales. It may be that these different perspectives are only transitory. Most of our London-based discussions took place early in our work, at a time when - as we mention above - the focus was on the devolution legislation rather than on health policy. With the passing of time it may be that there is a growing recognition by those who traditionally look to London as the 'policy centre' that in future the dynamic of policy formation will be different. But for our project, the possible tensions between

those who saw the need to resist divergence and those who saw devolution as the chance to be different, and the implications for the operation of the health systems post devolution, lie at the heart of our findings.

The opportunity devolution offers

7.4 In both Scotland and Wales, devolution is seen as an opportunity to address problems of poor health status, and to address health inequalities that exist in the two countries. In Wales, it is seen as an opportunity to return to the agenda pioneered by the former Welsh Health Planning Forum, and to put the pursuit of 'health gain' (adding years to life, and life to years) high on the Assembly's list of priorities. In Scotland the language of health gain is not used so frequently, but the same intent is evident.

7.5 The changes to the health services introduced by the Conservative government were generally considered to be alien to the 'communitarian' character of Scottish and Welsh society. For many in Wales and Scotland, devolution offers an opportunity to redress the situation. 'Taking ownership' had a hard edge for many of the respondents. It meant that excuses – that it was someone else's fault – could no longer be offered.

> 'The essence of being subdued is that you think the action is elsewhere'.

When challenged that devolution offered few new freedoms, and that existing freedoms in general had not been exploited, the response was that things will be different when health is debated, and decisions are made, on the floor of the Scottish Parliament or Welsh Assembly. Those with detailed knowledge of the resource issues and the challenges of the health status in their different countries accepted that 'taking ownership' would be at times a painful process, and certainly one that would only be accomplished after an extended period of time.

7.6 A major benefit of the 'return' of the health services to what was seen as local *democratic* control is expected to be the improvement of working relationships between the health services and local government. There are two reasons for this. The first is that the highly unpopular changes to the governance structure of the NHS have alienated local government in Scotland and Wales (as it did in England) and devolution is seen as an opportunity to redress the 'democratic deficit'. The second,

more 'technical', reason is that the smaller scale and easier communications in Scotland and Wales should make cross-departmental and cross-functional working easier.

Will models of healthcare diverge after devolution?

7.7 We tried to discover whether the ambitions for change in Scotland and Wales were likely to result in different models of health care developing. We found nothing to suggest that the concept of the 'National Health Service' is threatened by devolution, if by the 'National Health Service' is meant the set of core values and principles which have persisted since its founding. Indeed, the cultures in Scotland and Wales are thought to be more supportive of the principles of the NHS than that of England.

7.8 If the National Health Service is taken to mean the use of a particular model of health care, then the situation becomes less clear. In part, any conclusion may be affected by the way the concept of a 'model of health care' is understood, and the level of generality or aggregation at which models are defined. For us, there is considerable scope for divergence between the three countries in terms of health care planning, organisation and mamagement without any of them abandoning the basic 'health care model' in use. We find no evidence that Scotland or Wales have, developed and ready for implementation after devolution, models of health care that are radically different from those in use today. Change, if it comes, is likely to arise because the different health services adopt different 'evolutionary paths' from the current situation.

7.9 There is a school of thought which believes that, in Scotland particularly, devolution may result over time in the emergence of a health care system significantly different from that in England. Asked how this divergence might start, it is suggested, for example, that differences could begin to emerge over the role of GPs, if Scotland and England took different approaches to the GP role in controlling/influencing the allocation of resources for secondary care. Approaches to 'managed care', integrating primary and secondary care in a different way, are for some a possible development in Scotland. Others see the abolition of trusts as a possibility, or a different approach being adopted to the control of prescribing within the health service. But, as we reported in paras 5.6-11, the Scottish White Paper proposals do not at this stage suggest any radical departure from the thrust of policy in England and Wales.

7.10 The English White and Green Papers develop the concept of 'Health Action Zones', although with only limited additional challenge funding. In Scotland, there has been some discussion of the health service playing a larger role in community care. In Wales, those we interviewed thought that any change was more likely to involve a larger local government/social service involvement in health matters, particularly commissioning, with experiments in new locality-based 'commissioning' arrangements. Each country is looking for ways of bridging the health/social services divide, but each may come up in time with a slightly different solution.

7.11 Divergence, if it comes, will come initially through changes at the margins: either through experimentation in Scotland and Wales or through England introducing changes that Scotland and Wales do not want to adopt. How much real change will result, and at what speed, is extremely hard to forecast; but changes are most likely to be evolutionary rather than revolutionary.

Will the resources enable aspirations to be met? The Barnett formula and beyond

7.12 In both Scotland and Wales, maintaining the Barnett formula was considered extremely important. It was argued in Scotland that its favourable funding (at least 20% more than England's) was justified both by the extra expense of maintaining a health service in a country with large areas of very low population density, and with poor health status. Yes this cannot wholly explain the difference in funding between Scotland and Wales, which also has sparsely populated rural areas; nor between Scotland and Northern Ireland (see paras. 4.13 - 4.17).

7.13 In Wales, we heard of a desire to embed the Barnett formula in the legislation, something which is extremely unlikely to happen; or to extract a firm commitment from the UK government that any alternative means of resource allocation should be based on a 'bottom-up' needs assessment. It was recognised in both countries that financial pressures on the health services would continue post-devolution, and thus make it harder to meet the raised expectations from their citizens, which will be expressed in the Parliament/Assembly.

Issues of governance and accountability : Who will drive the vision and strategy?

7.14 There was recognition in both Wales and Scotland that, if the health agenda was to be advanced, strong strategic leadership was needed. There were two facets to this leadership issue. One was the

governance structure of NHS organisations, which is still resented in Scotland and Wales, and is believed to have affected adversely the working relationships between health and local government.

7.15 The Scots will have the chance to abolish completely the current system of trusts and Health Boards. They will be able, if they so wish, to abolish trusts, merge trusts and health boards (i.e. merge purchasers and providers), or transfer the powers of either to a third party (for example to local authorities.)

7.16 The Welsh will have more limited powers. They can reorganise health authorities or trusts, but not merge them (a series of Trust rationalisations is being planned currently and will be implemented before the Welsh Assembly is in place). They cannot abolish the purchaser/provider split, nor undo the new governance model entirely. But the power to appoint members of Trusts and Health Authorities will be devolved: so the Welsh Assembly could decide as a matter of policy (if not of law) to appoint local government representatives onto all NHS boards.

7.17 The second aspect of strategic leadership concerns the roles of the Parliament and Assembly, and of their members. This was an area of both uncertainty and concern for many respondents. The role of the Parliament and the Assembly as *strategic* bodies was important but there was considerable doubt that the two bodies will adopt a strategic orientation; there was much concern that the establishment of the two bodies would lead to an audit and scrutiny 'explosion', and the scope for 'turf wars' with local government and other parts of the public sector. In setting the tone and style of these bodies, the background, experience and character of the leading members and the supporting/influencing roles of the civil servants was considered crucial if the potential for strategic leadership is to be realised. The use of proportional representation offers an opportunity here, because the 'List' system will allow parties to put forward people with particular professional expertise or experience who could strengthen the competence of the Parliament and Assembly to develop their strategic roles. If this is done, the Parliament and Assembly may be able to draw on a wider range of talents than might be available if membership was provided only by 'career politicians', whether of the central or local government variety. It remains to be seen how the List system will be used by the different political parties. In practice it is unlikely that people other than career politicians will be selected as candidates: and only the minority parties will see many people elected from the list (because the majority party will take up its share of seats through its successful constituency candidates).

Rationing, access and cross-border flows

7.18 A major preoccupation of most health services in developed countries is the rising cost of health care and the limited ability of economies to support it. This has led to much debate about explicit rationing, and ways in which it might be done. (There is, and always has been, implicit rationing at the level of the individual patient as a result of clinical decision-making). There is no evidence from the political community or general public of any enthusiasm for experiments with rationing, in whatever form, in Scotland or Wales. Indeed, such an approach would run strongly counter to the 'communitarian' nature of their societies. However, the medical communities in both countries are aware that a debate on rationing will need to take place. Some Scottish doctors have recently held discussions about the need for overt rationing to escape the 'post-code lottery'. It may be that the more communitarian nature of Scottish society, and perhaps the greater respect it has for medical professional leadership, will enable such debates to take place without the overtones that have coloured such attempts in other societies. However, this remains to be tested. Rationing has been a highly contested issue in the English health service, and there are relatively few areas in which it is practised by health commissions. While there is much discussion currently, reflected in the White Paper, about clinical effectivenesss and the use of evidence-based medicine, rationing as such does not appear to be on the agenda. Indeed the increased emphasis on issues of equity and access within the English NHS in some ways runs counter to it.

7.19 In one area in which rationing has been introduced in parts of the English NHS, in-vitro fertilisation, overall Scotland has managed to resist the trend, although there are still differences between the different health boards. The chances of being offered IVF by the Scottish health service is seven times greater than in England. This may be a reflection of the comparatively more generous funding in Scotland. Whether Scotland and Wales will be able to resist debates about rationing if or when resources tighten will depend to a large extent on the capacity of their health services to innovate and do more with less.

7.20 A possible consequence of differential access to NHS-funded care in different parts of the UK is the development of 'cross-border flows', patients seeking access to services outside their home region. We found little concern about cross border flows between Scotland and England. The two countries are physically well-separated, with a large area of low population density separating the major English population centres with their Scottish counterparts.

7.21 The situation in Wales is significantly different. Not only are the countries linked by a major population belt and good communication links in the South, but North-South travel and communication within Wales is difficult. People in North Wales make significant use of the health services in the English North-West, around Liverpool and Manchester. There are also major cross-border flows into England from Mid-Wales, accessing the health services in Shropshire.

7.22 What lies behind these cross-border flows, in the main, is local geography and ease of access to acute and secondary care, rather than to gain treatment that is 'rationed' in Wales, or to access higher quality healthcare. As long as funding permits money to follow patients, the existence of cross-border patient flows is not expected to be the source of any major problems post-devolution. In the longer-term, if a different model of healthcare was to evolve in Wales, with a different mode or extent of access, the situation might change with English health services refusing to treat Welsh patients unless properly funded, or vice versa.

Education, training and research

7.23 The setting of professional standards will remain an all-UK issue, as will regulation of the medical professions. These are also areas in which the influence of the EU is increasing. We found no evidence of pressure in Scotland or Wales to challenge such arrangements. The area in which problems may arise is not in standards or regulation but the supply of trained medical personnel.

7.24 The funding of university education, including medical education, is devolved to the funding councils in England, Scotland and Wales (HEFCE, HEFCW, SHEFC). Scotland is a net exporter of qualified medical staff. It has four full medical schools and a fifth which operates in partnership with an English university, and currently produces around 20% more medical graduates than the Scottish health service needs. For many in the Scottish health service this is a strength. Scotland has the opportunity to recruit the pick of its medical graduates and export the remainder. There are fewer locums, and non-UK doctors, working in Scotland than in England. For Scotland, higher education, and medical education in particular, is 'part of its business', and those we interviewed considered it should not be challenged. But it is at least possible that, if there are significant pressures on public expenditure, some in the Scottish Parliament may wish to challenge this use of resources.

7.24 Some argue that Scotland has one more medical school than it 'needs'. There are several parts of England which have, for some time, had aspirations to have medical schools – for example Warwick/Leicester, Brighton and St. George's, Portsmouth. In addition, in Wales there are some ambitions for a medical school in Swansea in addition to the University College of Medicine based in Cardiff. It is not clear, post-devolution, how decisions affecting the supply of medical graduates might be resolved. A UK-level 'planning' approach would be seen as inappropriate, but a degree of cooperation may well be in the interests of all three countries.

7.25 The other concern about training was expressed in Wales, and concerned vocational training. It was argued that the vocational training system had placed so much emphasis on meeting the needs of industry, particularly manufacturing industry, that the needs of the caring professions were being neglected. However, devolution will give opportunities to redress the balance, if the Assembly so wishes.

7.26 Where basic research is concerned, there was general agreement that this is something that needs to be organised on an all-UK basis. The education systems in Scotland and Wales have insufficient 'critical mass' to sustain independent organisations funding *basic* research. The situation where Scottish and Welsh institutions compete for funding from the UK research councils received widespread support. In fact, Scottish institutions do rather better in the competition for funding than they would if research funding was devolved.

7.27 There are some membership organisations which support applied research with funds generated from a combined English and Welsh membership. There is some concern that, when such bodies fund research, topics of interest to the English membership receive undue priority. Devolution will have no direct effect on such behaviour, but it is something that the organisations concerned may need to address.

Human resource policies – terms and conditions etc.

7.28 Conventional wisdom is that terms and conditions of service for medical and nursing professionals need to be harmonised across the UK, otherwise staff will 'vote with their feet'. Some of our Scottish respondents challenged this view, on the basis that the 'playing field' was already uneven, and that this had not led to an exodus of qualified personnel. Scottish GPs, for instance, earn less

than those in England because list sizes are smaller. The earning potential of both GPs and consultants is less in Scotland because there is significantly less private medicine.

7.29 Given this, and the 'communitarian' culture, it was suggested that the Scottish Parliament might feel inclined to depart from the use of the 'maximum part-time contract' for consultant staff. GP fundholding is being abolished in all countries, but in the medium term experiments with new forms of 'managed care' could change the self-employed status of Scottish GPs. Such changes might be contested by the UK professional bodies, with their predominance of English members, if they were seen to have detrimental implications for England and Wales.

Professional networks – the need to prevent fragmentation

7.30 The medical professions mainly operate on an all-UK basis, with important networks within the professions, and between the professions and government. Currently, those in Scotland and Wales have full access to these networks. Some concern was expressed in Scotland that devolution may threaten access to such networks. Examples were given of committees being assembled by the Department of Health (presumably operating in its all-UK mode) where representation was now being confined to English clinicians, with Scottish (and presumably Welsh) input being sought via the Scottish (and Welsh) Office rather than direct from the service. Depending on how the Scottish and Welsh Offices conduct communication and liaison activities with their countries' health professionals, there is a concern by those in Scotland and Wales that they will become excluded from the networks in which they previously would have participated. There is a also concern that, if devolution does lead to a fragmentation of professional networks, this would lessen their value for the English as well as disenfranchise Scotland and Wales.

Relationships with Europe

7.31 Formal representation will be a matter for the UK, and will be managed by the International Unit of the Department of Health, as was discussed in para 6.12. There is little Scotland and Wales can do to challenge the formal position. But virtually everyone we consulted insisted that the two countries would wish to develop further their links with international bodies such as the EU and the WHO, and to forge bilateral links with individual countries. It is likely that concerns are as much about lack of opportunity to share information and learn as they are about involvement in decision-making. The

Department of Health's International Unit's dissemination of information to Scotland and Wales appears not to be highly regarded. This area potentially is a source of conflict post-devolution.

Supporting the policy process – the need to build policy networks

7.32 Post-devolution, Scotland and Wales will want to develop and evolve their health services to meet the health needs of their population. Development of both policy and practice needs to be supported by a strong policy analysis and policy development capability. This will be needed both *inside* the government machinery and also *outside*, in independent 'think tanks' or research units. Health policy in the UK has always benefited from the activities of organisations such as the King's Fund, the Nuffield Institute at Leeds, the Centre for Health Economics at York and the Health Services Management Centre at Birmingham. All these units are based in England, and were considered predominantly to address English or UK issues.

7.33 It was generally felt that the Scottish and Welsh 'health policy networks' were insufficiently developed. This applied both to the analytical capacity within the national governments, which was thought to have been drastically reduced (especially in Wales) and outside. Within the Scottish and Welsh Offices it was recognised that people were struggling with the extra burden of devolution while continuing to manage their every-day portfolios. There was little spare capacity for longer-term strategy development. Outside government there were some very capable individuals, or small units with a particular focus on some aspect of public health or health economics (e.g. the Welsh Institute of Health and Social Care at Glamorgan, or the Health Economics Research Unit at Aberdeen); but these lacked the necessary 'critical mass' to support a Parliament or an Assembly wanting to develop a strategic role in health policy.

7.34 Claimants to fill this 'policy development' gap are already emerging, although many start from a particular membership base or loyalty. There have been interesting developments even during the relatively short life of this project. Nevertheless, while in time the situation is likely to correct itself, many would support some early catalytic action to provide a focus for developing health policy capacity in Scotland and Wales.

Chapter Eight

Will there be a developing regional agenda in England?

The NHS in England: scope for an enhanced regional role?

8.1 This has primarily been a study of devolution and health in Scotland and Wales, and of how the health service in those two countries might develop as a result of devolution. But devolution has an English dimension as well. The secondary purpose of the study has been to explore whether the health service in England is going to need to develop a stronger regional dimension, as a direct or indirect result of the government's other policies. This could happen as a consequence of:

- knock on effects from devolution in Scotland and Wales
- the government's own agenda for regionalism in England, currrently focused on promoting economic development in the English regions
- other changes in the health service, and in particular the public health agenda, which may require a stronger regional tier to deliver the results the government is seeking.

The effects in England of devolution to Scotland and Wales

8.2 Conventional wisdom is that whatever happens in Scotland or Wales will have little significant impact on England. The English health service makes up around 85% of the UK total, and thus has a momentum and direction that are unlikely to be perturbed by whatever the other 15% does. Our fieldwork reflected this conventional wisdom; and the English participants in the Leeds seminar confirmed that there is little or no interest in what is happening in Scotland or Wales.

8.3 As a result there is unlikely to be significant pressure to reflect any Scottish or Welsh innovations in English practice. Even if some developments do attract professional admiration, the politicians in England are unlikely to be impressed. Other public services in Scotland such as education and the law have long been admired for their different aspects, but rarely imitated south of the border. Even if some health professionals might see a potential for learning from innovations in Scotland and Wales, we found no evidence that the English health policy agenda will be affected by developments in the neighbouring countries. We need therefore to see if there are other factors within England which might be drivers for an increased regional dimension in health policy.

The starting point in England: national not regional

8.4 Our initial investigations suggested that the NHS in England did not have a *regional* agenda; if anything quite the reverse. In abolishing the Regional Health Authorities and replacing them with Regional Offices of the NHS Executive the previous Conservative Government greatly increased the centralisation of the English NHS. The signs are that the new Administration plans to continue with this trend. One of the Secretary of State's main policy imperatives is to 'renew the NHS as a genuinely national service'. Alongside this is the objective of making healthcare delivery against new national standards a matter of *local* responsibility, and to encourage the NHS to work in partnership locally.

8.5 The Regional Offices are outposts of the NHS Executive. The English White Paper contains relatively little discussion of their role, other than in terms of performance management, monitoring the implementation of central policies and programmes. There are even hints that the Regional Office role might diminish in future:

> 'As fewer and larger Health Authorities emerge alongside the development of Primary Care Groups, the role of the NHS Executive Regional Offices will need to be kept under review'.

The English Green Paper similarly stresses the importance of national policies and local initiatives, seeing the role of Regional Offices very much as one of performance management:

> 'The Regional Offices of the NHS Executive will agree the plans and monitor the progress of the NHS in achieving the action laid out in the Health Improvement Programmes'.

Judging from the rhetoric of the English White and Green Papers, there is little or no place within the Department of Health's current plans for a regional level of strategy. The language is almost entirely binary - national policies and targets, local initiatives to meet them.

8.6 We believe there are nevertheless forces in play which may demand from the English NHS a regional, rather than local, response, and that a degree of strategic flexibility by the NHS at regional level may be required. The drivers for such change are to be found in the new Government's plans for devolution to the English regions, starting with economic development; and in the new policies for public health which may require stronger regional as well as local partnerships.

The government's regional agenda

8.7 The government's plans for regionalism in England were outlined in paras 3.8-10. They were summarised by John Prescott in his introduction to the White Paper on Regional Development Agencies as follows:

> "The Government are committed to move to directly-elected regional government in England, where there is demand for it, alongside devolution in Scotland and Wales and the creation of the Greater London Authority. But we are not in the business of imposing it. There is a lot we believe we can do within the present democratic structure to build up the voice of the regions. Local authorities are already coming together with businesses and other partners, to form voluntary regional chambers and to create a more integrated regional approach.
>
> 'As we set about our task to modernise Britain's economic performance ... we do so with the regions to the fore. The problems are well known. Poor skills, lack of investment, ... poverty, ill-health and a sense of hopelessness combine to reduce the performance of the economy ...
> Our vision is for the English regions to grow and prosper ... For economic development and the regeneration of local communities, the new Regional Development Agencies are fundamental".

8.8 The White Paper went on to say in chapter one that the approach to England's regional development is based firmly on four principles, which include "the belief that power should not be centralised in Whitehall, but that local, regional and national structures are needed for decision-making and for action to put those decisions into effect". Another was that "issues should not be tackled in isolation, but that much greater integration and coordination of effort is necessary to deal with the pressing need to deal with economic and social decay, and to promote the successful regional economies vital to our future prosperity" (para 1.4).

8.9 As bodies primarily concerned with economic development, health is not one of the RDAs' core functions. However, RDAs will 'have a major consultative and advisory role' in a number of 'non core' areas which include transport, land use, the environment and sustainable development, Further and Higher Education, crime prevention, public health and housing. Clearly, the RDAs will be

interested in the health status of their populations, not least because this will have an impact on competitiveness.

8.10 The pressure for greater devolution to the English regions is uneven, but in parts of the country - particularly in the North - there is growing enthusiasm for greater autonomy and more devolution from Whitehall. Bodies such as the North of England Assembly, the Regional Chamber for Yorkshire and Humberside, and the North West Partnership are active in developing their regional agendas, and in arguing the cases of their regions for investment and resources. Through their overlapping membership these regional bodies provide a forum in which local authorities, the Government Offices for the Regions and other regional stakeholders can meet to agree a strategy for the promotion of the economic, social and environmental wellbeing of their region. The NHS bodies in their regions will be important stakeholders and partners in their activities, both for the contributions that they can bring to improving the health of regional workforces, and as major regional employers in their own right.

8.10 The NHS is likely to come under increasing pressure from these new regional bodies to engage more fully in the regional development agenda. But there are two potential obstacles. One is how much room for manoeuvre the Regional Offices of the NHS will have to meet the expectations of their regional partners. For partnership to work the different partners need to be able to adjust their priorities and programmes to meet local circumstances and the needs of the other partners. The NHS with its strong central direction and demanding performance standards may find it difficult to develop a different set of priorities or allow too much variation at the regional level. If genuine regional partnerships are to develop the centre will have to learn to relax its grip.

8.11 The second obstacle is the perennial problem of boundaries. The geographical structure of the NHS Executive's Regional Offices is significantly different from that of the Government Offices for the Regions and the new Regional Development Agencies. In London this is recognised as a problem which will have to be addressed if the new Greater London Authority is to work effectively with the Health Service: the White Paper on *A Mayor and Assembly for London* says that "the government will also be undertaking work on the NHS Executive regional boundaries to take account of changes in the NHS and the creation of the GLA" (para 5.209). But it is not just in London that NHS boundaries need to be reviewed: if the Department of Health is serious about more effective joint working at local and regional level it needs to review Health Authority and regional boundaries as well.

Does the public health agenda require a stronger regional tier?

8.12 The English public health Green Paper recognises, in the context of addressing the wider determinants of health, the importance of connecting to, and harnessing the potential of, other Government programmes and initiatives. Thus

> "The regional arms of Government will also have important roles in the strategy. Government Offices for the Regions coordinate the main Government programmes such as housing, planning, transport, training, and investment in industry. The Regional Offices of the NHS Executive, with their Regional Directors of Public Health, oversee the work of the NHS locally. Working together these bodies should ensure that the potential of all Government programmes to support the health strategy is fully exploited".

8.13 The Green Paper does not go on to explain exactly how these bodies will work together, when they have failed to do so in the past. Effective coordination between the four departments represented in the Government Offices for the Regions is proving difficult enough. They are unlikely to bend their policies or programmes to support the health strategy unless they are offered some inducements to do so, in budgetary or other terms. And they are unlikely to support the health strategy simply in response to a diktat from the centre: regional partnerships need to develop and shape their own regional agendas, and to be given the freedom to do so. This will require the centre to be willing to let go.

Performance assessment and regional variation

8.14 Performance assessment is another centralising force. The Government proposes to adopt a new National Performance Framework, designed to be used both locally and nationally. The consultation document on a national framework for assessing performance ('*The new NHS - Modern and Dependable* : A National Framework for Assessing Performance', NHS Executive, January 1998) recognises the 'unacceptable variations' in performance across the NHS that currently exist. The White Paper acknowledges that the way in which performance is measured directly affects how the NHS acts. The consultation paper further comments that "asssessment of performance in the NHS needs to take account of the contribution made to improving health by successful partnerships

involving the NHS as an advocate for health, as well as the direct health care provided by the NHS".

8.15 In the draft framework, on which comments have been sought, two factors relate most closely to any competitiveness and regeneration agenda: *health improvement* (the overall health of the population, reflecting social and environmental factors and individual behaviour as well as care provided by the NHS and other agencies) and *health outcomes of NHS care* (NHS success in using its resources to reduce levels of risk factors, reduce levels of disease, impairment and complications of treatment, improve quality of life for patients and carers, reduce premature deaths). The consultative document suggests that 'the framework and the indicator set will encourage the development of further measures locally to assess and improve performance'. It is not clear what scope there may be for differential targets at local or regional level, to meet particular local or regional needs.

Conclusion: the scope for a regional health strategy

8.16 The national framework for assessing performance, and the way performance management is conducted in the NHS, is likely to have a major impact on the way any NHS regional role develops. The current Administration is strongly committed to 'holistic government', to breaking down 'functional chimneys' and to developing joined up thinking to tackle deep seated social problems. Devolution could be one of the ways of achieving a more holistic approach. The Department of Health may need to adjust to the developing regional agenda. The more the RDAs widen the scope of their activities and start to impinge on some of the key areas affecting people's health (as defined in the Green Paper, such as housing, transport, physical regeneration etc), the greater will be the need for effective collaboration with the NHS.

8. 17 In its local structures the NHS has often sought to achieve co-terminosity with other major stakeholders, especially local authorities. To fail to achieve this at regional level between the NHS and the RDAs would seem difficult to justify. (The Turnberg review of London health services recently concluded that a single London regional office for the NHS Executive should be the longer term aim. This would align that part of the NHS with the proposed RDA structure.) But is the pressure for a *strategic* role for the NHS at regional level, or simply for a regional structure that will ease communication and liaison with other regional bodies? In other words, is there - or will there be - scope for a regional level strategy which 'adds value' to health activities locally within the regions? Much will depend on how the RDAs develop, how they are judged by the public, and whether the

demand is for more rather than less regional government. But if the demand is for more, it seems unlikely that the NHS could stand outside an increasingly dynamic regional level of policy development. As it is, the objectives of the public health Green Paper are likely to be furthered if the NHS is an active participant in the development of regional regeneration and economic development strategies.

Chapter Nine

Reflections on our findings

9.1 In the previous section we reported the views of our respondents. Before turning to our conclusions, we wish to offer some observations and reflections on the situation as we found it. These draw in part on our experience elsewhere, mainly in the field of organisational change.

The devolution process as it affects health

9.2 In the course of our interviews we gathered a lot of information about the run-up to devolution. We could not avoid comparing this process with that which was carried out in England when the Regional Health Authorities were abolished. In that instance a fundamental review of all the RHA functions was carried out, with appropriate involvement from those in the health service who would be affected by any change. This 'Functions and Manpower' review systematically addressed everything that the RHAs did, decided whether the activity should continue, and if so who should carry it out. This does not seem to be happening as the health services are devolved.

9.3 For the optimists, this is not a problem and once the Bills are passed there will be time to work out the implementation questions about the roles of the Parliament/Assembly and its members, and the systems and structures required to support them. They would also argue that some of the uncertainty was deliberate, because where appropriate issues should be left for the Parliament or Assembly to decide once they come into existence. The pessimists take another view. They point to the current workload in the Scottish and Welsh Offices, where the major task of preparing for legislation has to be carried out alongside the everyday work, and efficiency savings have already reduced policy capacity in the 'core executive'. For the pessimists, there is both insufficient time before the Parliament/Assembly 'go live', and insufficient policy/analytical capacity, to address the gaps. The need for careful consideration, and scrutiny, of issues such as the transfer of powers orders to the Scottish Parliament and Welsh Assemby and the 'concordats' to be agreed between Whitehall Deparments and their counterparts in Cardiff and Edinburgh, was stressed repeatedly.

9.4 Given the UK's capacity for poor legislation and policy disasters (see P. Dunleavy, 'Policy disasters : explaining the UK's record', Public Policy and Administration, 10, 2, 1995), we were concerned

about the apparent lack of an equivalent of the 'functions and manpower' review for the post-devolution health services. A phrase much quoted in Wales, and attributed to the Secretary of State, described devolution as 'a process, not an event'. Yet what we found, at least in the early stages of our work, was that the event was consuming all the energy. If so, post-devolution the Parliament and Assembly may be faced with a less-than-ideal 'playing field' on which to conduct policy development and implementation.

Conducting policy in a devolved system – how the parts relate to each other

9.5 If devolution in health is to work, it must be supported not merely by systems and structures, but by a sound understanding of the roles and the relationships between the decision-making bodies at the different levels. Three models can be used to explore these roles and relationships, which can be termed 'corporate', 'collaborative' and 'federal'.

9.6 In the 'corporate' model, the analogy is with the modern multi-business organisation. This model is one based on ownership and control, with the 'centre' determining the objectives for each of the operating units (or, at least, maintaining the power of veto). The corporate model is hierarchical, and conventional wisdom is that the centre/corporate level should do nothing unless it 'adds value' to that which the operating units do.

9.7 The 'collaborative' model starts from the opposite viewpoint. In this, organisations are independent bodies with full control over their strategies and resources. There is no hierarchical relationship. However, they do not necessarily have the full range of competencies required, or the scale to tackle some types of problem. They may decide voluntarily to collaborate, by pooling scarce resources, coordinating activities, making mutual arrangements which yield scale economies. Collaboration is voluntary, reversible, and while not cost free, it does not involve threatening the viability or raison d'etre of the organisations concerned. A good example would be the 'lead authority' arrangements which have been made in England between some health authorities or social services departments.

9.8 The third model might be termed a federal one, and it shares some of the characteristics of the first two. In this the members yield power over some issues to the 'Federation', which develops at its core the competences to deal with them. What is a 'federal' issue and what is a 'state' issue is usually clear cut, and this model differs from the corporate one in that the 'Federation' cannot collect

more power to itself unilaterally.

9.9 Legally and constitutionally the devolution relationship will formally be a corporate one. The Government's devolution White Papers emphasise the continuing sovereignty of the Westminster Parliament, which will retain the power to override the devolved assemblies or to amend the terms of the devolution settlement. This is in contrast to the attitude of our interviewees, few of whom would accept a 'corporate' model as an appropriate analogy for the relationship between the Scottish and Welsh health services and the UK NHS. They thought more in terms of a collaborative or federal model (but we did not put the models explicitly to them).

9.10 There is another danger which has been encountered in industry where a multi-divisional firm has one business significantly larger than the others. Its ways of working (structures, financial and administrative systems, etc) tend to be dominated by the needs of the large business, sometimes to the detriment of the others. If the corporate headquarters are based at the same site as the major factory, confusion can abound and the distinctive corporate level contribution in 'adding value' gets overlooked. The Department of Health has a mixture of all-UK roles and England only roles. Often the same people may be involved at different times in both of these. The danger is both that the needs of England (the 85% of the population) will drive structures and systems that are less than ideal for Wales and Scotland; *and* the separate interests of England may at times be submerged by the UK-level agenda..

Governance, audit and strategic direction

9.11 The effect of devolution will be to return the Scottish and Welsh health services more to local democratic control. The 'village' effect in Scotland and Wales will strengthen this but will the new forms of governance advance or retard the performance of the Scottish and Welsh health services?

9.12 Others, in writing about corporate governance processes in business, have described two different functions to be carried out: conformance and performance. Conformance, as the term suggests, is concerned with the provision of accountability externally and tends to be dominated by monitoring and supervision activities internally. It therefore tends to be more inward looking than externally directed, and is in the main past- and present- oriented. The performance role concerns the way an organisation's performance can be enhanced and, by contrast, is future oriented, often outward

looking and focuses on strategy formulation and policy making. It has been argued that too much attention has been focused on the conformance role of governing bodies, and much less on the board's role in promoting improved performance.

9.13 Respondents were concerned that tighter democratic scrutiny would lead to increased emphasis on conformance, to the detriment of performance. While issues of accountability are important, particularly in the communitarian cultures of Scotland and Wales, if scrutiny and accountability becomes too dominant then the strategic leadership of the processes required to improve health status and reduce inequalities will be lacking. The style of leadership, and the expertise provided by the members, of the Welsh Assembly and Scottish Parliament, will be crucial in striking the correct balance between focuses on conformance and performance.

Behaviour will be different – be prepared!

9.14 Organisational 'separations' of various sorts are often followed by a period in which former colleagues behave in a surprisingly hostile manner. It seems part of the process of gaining and exercising independence that relationships become more adversarial as people test out their new freedoms and push against the boundaries of their new roles. This was certainly the case with relationships between health authorities and trusts after the purchaser-provider split was introduced. Some of those involved have commented that it was around three years before relationships settled back into a more collaborative style. The same may happen in the health services after devolution.

'Different', not 'better' or 'worse'?

9.15 The health services in all three countries face major challenges, stemming in large part from the demographic and economic realities. Already under financial pressure, the requirement to do more with less will continue. There is a need for continuing innovation in the face of these challenges. Will what is likely to emerge in Scotland and Wales meet this challenge?

9.16 Many in the Scottish and Welsh health communities, in particular those in public health and community medicine, appreciate the need for innovation. But in the general public's mind, devolution may be thought to offer the chance of 'getting back to the old health service' and rolling back the changes of the Conservative years. If people are expecting this of devolution, they are likely

to be disappointed. Whatever the future of the Barnett formula, the Scottish and Welsh health services will be under severe financial pressure which is likely to force the pace of change, whether it is welcomed or not. The rate of innovation in Scotland and Wales must increase rather than decrease.

9.17 The context presented by those parts of Scotland (and to a lesser extent some parts of Wales) with very low population density and widely scattered centres of population offers much scope for innovations such as the use of remote imaging and diagnostics, 'telemedicine', changing the skill mix in the health services and so forth. Similarly, the existence in Scotland and Wales of well-defined populations suffering from poor health status and health inequalities, such as some former mining communities in the Welsh Valleys, offers scope for innovation in achieving 'healthy communities'. Scotland already has one of the most successful WHO 'Healthy Cities' projects. If the resources are available for experimentation, there is a chance for Scotland and Wales to demonstrate European leadership in such areas.

Chapter Ten

Conclusions

Two alternative scenarios: little change, or growing divergence?

10.1 This has been a limited study. We have canvassed as diverse a range of views as was possible, but we have been unable to survey all 'stakeholder groups' systematically and in depth. We cannot predict with certainty what is going to happen post-devolution; nor recommend confidently what needs to be done to 'make devolution work'.

10.2 Our findings can be drawn together by summarising those factors which tend to suggest a 'little change' scenario, and another set of factors advanced by those who foresee a more radical divergence of the three health services, although not necessarily the emergence of different models of healthcare. These factors can be grouped under four main headings: political, professional, technical and attitudinal.

10.3 In the 'minimalist scenario', the factors which indicate that there is likely to be relatively little change include:

Political constraints

- devolution offers the health service in Scotland and Wales few 'new' freedoms. Most of these freedoms exist already, but have not been used.
- the Scottish and Welsh Labour Parties may feel constrained not to undermine the policies of the Labour government in London. Most respondents took the view that pressures for divergence would be lower when the same political party was in power in the three countries.
- tighter political accountability may make it harder for the health service to implement 'unpopular' decisions, ie close an A&E department or a maternity unit etc. 'Parochialism' may become worse.

Professional constraints

- the professions exert a dominant influence on the health agenda, and professional bodies (mostly UK/GB) have strong incentives to maintain conformity in standards of clinical practice, education and training, terms and conditions of service

- the difficulty of negotiating and mediating change between the various professional stakeholders.

Technical constraints

- high levels of fixed capital and manpower costs, the monopoly power of acute service providers, limited supply and skill-mix of qualified staff etc
- continuing or increasing funding constraints; Scotland and Wales are likely to have less money not more thus making experimentation harder.

Attitude constraints

- the unwillingness or inability of local politicians to break away from managing services, and adopt a more strategic role
- the predominance of short term and crisis management, 'shroud waving', focus on waiting lists, the 'perverse' influence of intermediate performance indicators
- lack of imagination or 'croneyism' in board appointments by local politicians
- expectations of equity, reinforced in Wales by the dominance of the national (UK) media.

10.4 On the other hand, those who argue that change will be greater, and that the three health services will being to diverge more, and more rapidly, cite as drivers for change in Scotland and Wales:

Political factors

- the belief that local politicians will develop a strategic view, through closer access to health professions, and have more legitimacy to introduce change.
- more vigorous democratic scrutiny should lead to improved performance
- the pent-up resentment against 'English' health care reforms, combined with pressures on the Scottish Parliament and Welsh Assembly to show instant results.

Professional factors

- the eagerness of many health and other professionals to provide leadership in developing new, appropriate, approaches to health and healthcare

Technical factors

the existence of 'policy villages', i.e. tight groups of political and professional networks which can ake for quicker and easier agreement over policy and strategy

- Health gain policies, which require coordinated action across departments, being easier to *operationalise* in Scotland and Wales, as the smaller size of the administration and the ease of communication makes it easier to overcome 'functional chimneys' and work across departmental boundaries.

Attitude factors

- the greater respect for, and acceptance of, 'professional expertise' in Scotland (and possibly Wales) which may mean that politicians and citizens are more inclined to accept 'technocratic' solutions.

10.5 The future evolution of the three health services will be determined by the interplay of these factors. It is too early to say which will win out in the longer-term; but probably the most important single factor is the quality of the new political leadership in Scotland and Wales.

Problem areas post-devolution

10.6 There is the potential for a significant amount of friction as the devolution settlement beds down. This will be affected as much by the style and culture adopted within the different health communities as by the substantive policy content or service operation. Devolution will require a different mind-set to apply in many areas of the health services, both those in the centre in Whitehall and in the UK professional bodies, as well as in Scotland and Wales.

Contentious issues are likely to include:

10.7 Possible differences of opinion over human resource issues, such as the consultants' contract and the GPs' contract, and over aspects of regulation such as prescribing policy and relationships with the pharmaceutical industry.
Possible response: This is what devolution is about, and countries must have the freedom to change. Maintaining 'inclusive' professional policy and advisory networks will maximise the potential for collaboration and for avoiding policy decisions that cause problems for other countries, but the problem comes with devolution!

10.8 Agreeing the mechanisms for determining the funding of health services, if the settlement delivered

by the Barnett formula is inadequate to address the aspirations of the Scottish and Welsh health services or if the formula breaks down.

Possible response: Agree to a fresh, needs-based assessment of the basis for public expenditure, conducted by an independent commission the members of which are appointed jointly by the respective governments.

10.9 The strong desire in both Scotland and Wales to form direct health policy links with international bodies such as the European Union and the World Health Organisation, which may pose a significant challenge for the operation of UK-level 'international health policy'.

Possible response: Scotland and Wales will be unable to change the formal mechanisms or challenge UK-level representation. Ensure effective consultative machinery exists so UK delegations are briefed on national views. Include Scottish and Welsh representatives in delegations. Recognise the importance of effective information dissemination and communication in creating a 'culture of inclusion' in UK policy matters.

10.10 The manner in which those health policy matters reserved for decision and action at the UK level, of which the above is a particular example, are conducted. This needs to take account of the Scottish and Welsh health services' desire for greater freedom and influence in such matters.

Possible response: Here too the solution lies mainly in negotiating and consultative machinery. There may need to be a UK Health Consultative Committee, in which the Health Ministers from England, Scotland, Wales and Northern Ireland come together to discuss such matters; accepting that the English Minister is also the Minister for the UK, who will have the defend the policy to Scottish and Welsh MPs in the Westminster Parliament.

10.11 The need to collaborate in areas such as education and training, where the number of medical schools and the output of graduates is determined by the three countries but where a degree of coordination over supply and demand may be appropriate .

Possible response: Recognise that no form of UK-level ' planning' is likely to be acceptable in such areas. The three countries must negotiate appropriate solutions among themselves, and individual countries must retain the right to 'go it alone' if they wish.

The modus operandi of many of the UK-wide professional bodies, the ways they relate to their memberships in England, Scotland and Wales, and the way they relate to the three countries' health services.

Possible response: This is a matter for the professional bodies themselves. They will need to review their governance, communication and consultation mechanisms in the light of the changed atmosphere and expectations that will result post-devolution. Many bodies are already addressing this agenda.

The need for health policy communities

10.13 The health services in Scotland and Wales would benefit from strong 'health policy communities' to provide independent analysis, generate fresh ideas and support more effective policies and practices. At present the health policy community is focussed on Whitehall, and largely based in England. There is a need to stimulate further development of policy capacity in Scotland and Wales. How might this be done? A significant contribution to the growth of the health policy community in England was made by charitable sources (The King's Fund and the Nuffield charities among others). In Scotland and Wales there are far fewer sources of charitable funds. A certain amount of 'seedcorn' funding, perhaps from the respective health departments, could make a major impact: or from Millennium or lottery money (The King's Fund endowment came from public subscription for Queen Victoria's diamond Jubilee).

10.14 When we talk of health policy support, we do not envisage a grand institution, nor do we envisage basic research of an academic nature. This is already reasonably well-supported. Any new policy capacity should

- have strong links to the health services and user communities
- feature extensive 'practitioner' involvement (practitioners being policy makers, politicians/members of governance bodies and managers as well as medical practitioners)
- focus on policy analysis, policy evaluation and policy implementation rather than basic research.

10.15 In addition, any such policy capacity should act as a focal point for those individuals and institutions already active in Scotland and Wales. It should be an 'inclusive' network, and should seek to maximise involvement and communication, utilising the latest technologies to do so. Because the health services in Scotland and Wales face particular challenges, it would be appropriate for any new policy research to maintain a relatively narrow focus. Thus one respondent suggested that new

Scottish health policy capacity might focus on

- health inequalities
- interventions in society and how they can generate better health
- healthy cities/communities.

10.16 While we received no such 'shopping list' from our Welsh contacts, there is already an established agenda around health gain and public health, on which further initiatives might be based.

What will be the outcomes? Will health status improve?

10.17 The desire in Scotland and Wales is to make the improvement of the nations' health a central focus of the work of the Parliament and Assembly respectively, to tackle 'health inequalities' and to work for 'health gain'. This is coupled with a strong, culturally-based, distaste for the Conservative government's reforms, particularly the internal market and the governance model imposed for trusts and health authorities/health boards.

10.18 Will the new strategies to be adopted in Scotland and Wales differ significantly from those to be adopted in England, and will they prove more effective in improving health gain and addressing health inequalities? What is important is to establish clear performance measures that will indicate what is happening. The consultations on the English and Scottish public health Green Papers are a start to this process. Possible measures might include:

- **reduction of inequalities in public health**

  Measures of success: improvement over time and against the rest of the UK, in standardised mortality rates, limiting long-term illness etc

- **maximisation of the population's health gain**

  Measures of success: absolute health gain and health gain relative to the rest of the UK

- **equality of access to healthcare facilities**

  Measures of success: take up of services by different socio-economic groups, waiting lists, etc. Interventions unavailable through the NHS.

- **more rigorous monitoring of outcomes**

  Outcome measures for standard interventions need to be developed, applied routinely and made publicly available.

- **democratisation**

  Measures of success: Opinion poll evidence of public satisfaction with the health services; attitudes revealed by media coverage; incidence of complaints/litigation? How to measure the degree of 'fit' between what the people want and what politicians and the service are able to provide? Indications of public acceptability of governance arrangements; increased effectiveness of local government/health services joint working

- **innovation and experimentation**

  Measures of success: the rate of innovation in the Scottish and Welsh health services; uptake of new technology/techniques/organisational approaches; implementation of evidence-based medicine, protocols etc.

10.19 Establishing a more definitive set of indicators and monitoring performance against them might be an early task for the newly-invigorated health policy communities in Scotland and Wales. An impartial assessment of performance is crucial; and it may also encourage the politicians to think and plan long term - because few public health interventions deliver results in the short term.

Chapter Eleven

Looking to the Future

11.1 In introducing devolution, to Scotland, Wales and the English Regions, the UK is entering unfamiliar territory. Policy formation and implementation in the devolved system will offer new opportunities but also present new challenges. It will be important that all those involved learn quickly from their early encounters in the post-devolution world, and if necessary evolve and adapt their ways of working together.

11.2 In health policy too there are changes. In all three countries the new strategies have common elements, although with local differences. Although not perhaps as radical a departure in organisational terms as was the introduction of the internal market, there are considerable challenges in many aspects of the new health policies. These include the operation of the new arrangements in primary care, the development of 'clinical governance' and the increasing stress on clinical effectiveness and the use of evidence-based medicine. There is also much room for learning here.

11.3 In carrying out this study, we have been aiming at a moving target, and examining a process that has a long way to go. We have tried to sketch out a road map of some of the early stages, but it is difficult to look too far ahead. It will be important to put in place some form of monitoring process which will indicate if devolution in health is 'working', and which will point to areas of policy and practice where change or improvement is needed. What might such a monitoring process observe?

11.4 When we asked those we consulted during this project what they would use to judge whether, in the case of Scotland and Wales, devolution in health was 'working', the answers were reasonably clear. As we reported above, judgements would involve whether the two countries were really taking responsibility for their populations' health, and addressing health inequalities, and in the longer term whether people's health status was improving. But the first is difficult to evaluate, and the second will become clear only in the medium to long term. (In the case of England, it seemed too early to ask the question.)

11.5 Any monitoring process has two aspects. Partly it needs to be about some of the 'technical' aspects of health and healthcare, but partly it needs to involve learning about *the process of policy change.* To achieve these two objectives would require a multidisciplinary approach. The agenda to be covered is wide, but from our analysis of developments so far, we suggest there are some key areas on which monitoring might focus. A number of these relate to the potential problem areas we

discussed in the previous chapter. The monitoring process might address the following questions, inter alia:

- How will the Scottish Parliament and Welsh Assembly influence the development of health policies and strategies? Will their activities focus on strategic leadership or will tactical issues of audit, supervision and accountability dominate?

- Will the different political parties use the proportional representation system for electing members of the Scottish Parliament and Welsh Assembly to ensure that health (and other) experts are included?

- Will Scotland and Wales, with their characteristics as 'policy villages' prove more effective at avoiding the 'functional chimneys' of public policy than the UK government has, thus delivering 'joined up government'? What mechanisms will be developed to achieve this?

- If, as is likely, resources are limited, will Scotland and Wales develop more effective, and more publicly acceptable, ways of addressing 'rationing' decisions, either within health or between health and other priority areas?

- Will the English health service be able to play the full part in the development of regional economic and other strategies that their partners in the regions require? Will Regional Development Agencies and Regional Chambers be able to engage appropriately with the debate on health policy, priorities and resource issues?

- How effectively will UK-level health policy be conducted, e.g. in respect of European and other international matters, and in those areas which are 'reserved'? Will the principle, or the detail, of 'reserved' powers come under pressure? Will both the politicians and the health professionals be content with the mechanisms used and the policy outcomes?

- How, if at all, will the various health and health-related professional bodies adjust their governance structures and operating methods to reflect the post-devolution situation?

- How will professional bodies' involvement in UK-level policy development be secured post-devolution, and will the health professionals in Scotland and Wales consider the mechanisms appropriate? Will there be increasing pressure for separate professional bodies in the three countries?

- Will UK professional bodies/associations still provide an effective way of learning from innovations in policy, practice, organisation and management across England, Wales and Scotland?

11.6 Appropriate investment at this stage in the design of some 'tracking studies' which could illuminate these, and other, questions as devolution progresses could be extremely valuable. There is significant potential for shared learning from the array of constitutional and policy innovations on which the UK, Scotland, Wales and England are embarking.

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