

Devolution and Health

**First Annual Report of a Project
to monitor the impact of devolution on
the United Kingdom's health services**

**edited by
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Paul Jervis and William Plowden

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The Nuffield Trust
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STUDIES IN HEALTH SERVICES

Foreword

John Wyn Owen, CB, Secretary, The Nuffield Trust

The Nuffield Trust's main aim is to provide opportunities for exchange and discussion of ideas, new knowledge or insights which can contribute to the medium- and long-term health and health services policy agenda of the United Kingdom. One of the main themes of the Trust's programme is, 'The changing role of the state - globalisation and devolution'.

Some two years ago, as the Government's plans for political devolution to Scotland, Wales, Northern Ireland and the English regions began to be implemented, the Trust invited Robert Hazell and Paul Jervis of the Constitution Unit at University College London to examine the implications for the different countries' National Health Services.

Their report, *Devolution and Health*, found no evidence that the core values and principles which underlay the NHS were likely to be adversely affected by devolution. However, it did identify the scope for considerable variation in terms of health service policy, organisation and management. It also detected signs that devolution might threaten some of the UK-wide professional and policy networks in health through which information and learning was disseminated.

As well as indicating a number of areas in which policy or administrative differences might arise post-devolution, Hazell and Jervis commented that there was considerable potential for shared learning from the array of constitutional and policy innovations on which the UK and its constituent countries were embarking. They recommended the establishment of a monitoring programme focusing on devolution and health. The Nuffield Trust has been pleased to support the establishment of such a monitoring programme, of which this first Annual Report is a product.

The former Secretary of State for Wales described devolution as a process not an event. We are still at a very early stage in this process. This Annual Report describes the context in which health policy is being developed in the four governments of the United Kingdom, and thus provides a 'baseline' against which future changes can be assessed.

At a time when there is a considerable national debate about how the future of the UK health services can be secured, the changed arrangements for their governance and accountability are of potentially great significance. It is on these topics that this monitoring programme will concentrate. The National Health Service is often named as one of the institutions that binds the United Kingdom together. The Trust intends to give priority to

ensuring that lessons from innovation and experimentation in health policy, wherever these occur, are disseminated across all the health services. It is grateful to the Constitution Unit, and their partners the Scottish Council Foundation, the Institute for Welsh Affairs, Democratic Dialogue and the Department of Politics at Queen's University Belfast, for producing this valuable account of the early days of devolution in health.

Devolution and Health

First Annual Report of a Project to monitor the impact of devolution on the United Kingdom's health services

Introduction

This is the first of three annual reports of a project, sponsored by the Nuffield Trust, to monitor the effects on the health services of England, Northern Ireland, Scotland and Wales, and on the UK NHS, of the changes in systems of governance and accountability resulting from political devolution.

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

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

The preliminary results of this investigation were discussed at seminars held in London, Cardiff and Glasgow, and a final report, *Devolution and Health*, was published by the Nuffield Trust in June 1998.

The Report noted that the processes of change in the NHS had been composed of two parallel agendas, with the introduction of **political devolution** being superimposed on the **health service reforms** introduced by the new Labour government. The changes in the health services had been developed within the system of **administrative devolution** to Scotland and Wales that existed in 1997. Although the three countries shared a common need to improve their populations' health and address health inequalities, and faced many common problems, the report's analysis suggested that it would be unreliable to use the then current proposals for health service reform in England, Scotland and Wales to assess the potential for greater policy divergence in future. (Note: Northern Ireland was not covered by this first study)

The Report found no evidence that the core values and principles which underlie the NHS in England, Scotland and Wales were likely to be adversely affected, or indeed much changed, by political devolution to Scotland and Wales. If the 'model' of the 'NHS' is described in broad terms as a service funded by general taxation, accessible to all, and free at the point of delivery, then there was little evidence of different models of health care emerging in the different countries. Without threatening fundamental principles and values however, there was scope for considerable variation in terms of policy, organisation and management.

Even if the same general model of health care were to remain in use in the three countries, there would remain room for considerable innovation and experimentation in governance, organisation, management and service delivery. There were signs that devolution might threaten some of the UK-wide professional and policy networks through which information and learning was disseminated. There was a need therefore to ensure that learning from policy and organisational innovation and experimentation continued to be shared across the UK's health services.

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

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

The report also pointed to the possible benefits from devolution for health policy and the management of the health services in Scotland and Wales. In responding to the health agenda, they had some advantages over England. The 'policy villages' in Scotland and Wales, with tight political and professional networks, could make for quicker and easier agreement over policy and strategy. Further, health gain policies should be easier to implement because the small scale in Scotland and Wales would make it easier to work across departmental boundaries.

The Devolution and Health Monitoring Project

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

From the perspective of citizens as well as of health professionals, the real test of devolution

will be its effect on the health of the people of England, Northern Ireland, Scotland and Wales. Will the new governance arrangements enable the specific problems of Wales, Scotland, and Northern Ireland - including their relatively poor health status - to be addressed effectively? And how will the NHS in England develop in comparison with the health services in these relatively smaller jurisdictions? However, changes in *outcomes* may take many years to work their way through. The more immediate impacts of devolution will be on the processes of governance and accountability within which the health services operate. It is on these processes that we aim to focus. We are not uninterested in the specific *content* of health policy. We do wish to see, for example, whether the countries adopt different approaches to primary health care, or whether the way 'evidence-based medicine' is implemented differs, but our primary focus is on the policy *process* and associated issues of governance and accountability.

We set out to observe:

- the composition and activities of the new Health Committees in the Scottish Parliament, Welsh Assembly and Northern Ireland Assembly;
- the issues they choose to examine and the way they function;
- the strategic direction given by the respective Health Ministers;
- the governance arrangements they establish (for Health Authorities and Boards, hospital and primary care trusts, and so forth);
- the democratic accountability of these structures;
- the different methods used by the new administrations to deliver 'joined up government', and the effectiveness of these;
- the ways the Health Services develop links with Social Services and other agencies;
- the budgetary and audit arrangements that are established and the ways they operate.

Given the changes which devolution brings to the policy process at UK level, we are also setting out to observe, in the context of health policy, the conduct of 'inter-governmental relations' (the transactions between the devolved administrations in Belfast, Cardiff, and Edinburgh and between them and the United Kingdom government in Whitehall). Specifically, we intend to monitor:

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

We hope that the commentary that will result from this work will contribute to assessments, inter alia, of:

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

In the medium term, we hope to produce information about:

- how the debate about funding for Northern Ireland, Wales, Scotland and the English regions develops and the implications for health;
- whether the rationing debate develops further in any of the countries and whether Northern Ireland, Scotland and Wales develop more effective, and more publicly acceptable, ways of addressing ‘rationing’ decisions;
- whether the English health service can play its full part in the development of regional economic and other strategies that their partners in the regions and London require;
- whether the new English regional institutions are able to engage appropriately with the debate on health policy, priorities and resource issues.

As the monitoring process proceeds, we hope it will be possible to provide a commentary on the appropriateness of these new relationships for the governance and management of a system which can deliver improved health and health care in a devolved United Kingdom. We recognise that these are ambitious objectives for a project with relatively limited resources. Moreover, the issues we are addressing do not lend themselves to any single, simple, research methodology. To address them, we are trying to access multiple sources of information and in particular to link closely to the policy and practitioner communities in the four countries. To this end, we have worked with research partners in Northern Ireland (Department of Politics, Queen’s University Belfast and Democratic Dialogue), Scotland (The Scottish Council Foundation) and Wales (The Institute of Welsh Affairs). We look to each of our partners to maintain a ‘health network’ which includes representatives of all the key ‘stakeholder groups’, including those in the political arena (national and local), national and

local government, health service managers, health professionals, academics and lay members involved in the governance and management of health. Developments in England, including those in the English regions and London, have been monitored by the Constitution Unit team, which is also monitoring inter-governmental relations in health.

The first steps - an overview

This report contains the first annual reports from the partners in Northern Ireland, Scotland and Wales, together with some observations on developments in England. As we discuss below, it is still very early to start analysing the differences in approach to health policy, and health services management, within the various administrations. A major purpose of the country reports is to provide a 'baseline' against which future changes can be measured. So that we might capture any emerging diversity, we have not sought to impose a standard 'template' on data collection or its presentation. Each partner has been responsible for deciding their own research priorities, and investigative methods, consistent with the overall objectives of the monitoring project. The information presented below covers many of the same topics, but the structures and emphases of the reports vary. Subsequent reports will focus more closely on issues of governance and accountability. The aim at this stage is to outline the contexts in which such issues will emerge.

We cited in the *Devolution and Health* report the assertion by the former Secretary of State for Wales, Ron Davies, that "devolution is a process, not an event", a view we endorsed. It is, as we have said, very early in this process to draw even tentative conclusions. In two of the four countries, Scotland and Wales, devolved administrations have been in place for only approximately six months, since 1 July 1999. In Northern Ireland devolution has been a fact for less than two months as we write, having started in December 1999. England's devolution is both less radical in extent and less well-advanced. The Regional Development Agencies have been in place for nine months, but the elections for London's Mayor and Assembly are still some months away, in May 2000. So the United Kingdom's devolution is both asymmetric in constitutional terms, and asynchronous. What can we learn from what we have observed so far? How far do the developments observed fit the predictions of the first Devolution and Health report? And what are the straws in the wind?

Two contextual issues of great potential significance are, first, the relatively poor health status, as measured by indicators such as infant mortality, adult life expectancy, etc., of the populations of Scotland, Wales and Northern Ireland compared to England. And yet England's overall figures are not outstanding in international terms - a point that received much public comment in 1999 - and also mask areas of poor health status and severe deprivation. The second issue is the large share of the total budget for which each of the three governments is responsible taken by health and related services. These two facts must be seen in the context of the 'Barnett formula'. The UK government allocates to Northern

Ireland, Wales and Scotland a share of UK public expenditure significantly greater per head than the UK average. There are already strong pressures to revise the allocation formula. The new governments potentially are faced with a mismatch of needs and resources which can only become more marked, and whose consequences could be of great significance.

1999 saw the elections to the Scottish Parliament and the Welsh Assembly; the Northern Irish Assembly was elected in 1998. In the elections in Scotland and Wales, while the Labour Party secured the largest number of seats, in neither country did it achieve an overall majority. The consequence was the formation of a formal coalition government (Labour and Liberal Democrat) in Scotland and the formation of a minority Labour administration in Wales. The d'Hondt system used in Northern Ireland was designed to produce a multi-party administration. Therefore, only in Westminster is there still government by a single majority party. The new administrations face a challenge for which no previous Westminster experience has equipped them. As well as the fact that there is no party with an overall majority, the other significant feature of the Scottish Parliament and the National Assembly for Wales is the size of the representation from the nationalist parties.

One of the most significant implications of this is the potential that results for 'single issue politics' with particular cross-party coalitions/partnerships forming around a specific issue. 1999 saw several preliminary skirmishes where the governments of Scotland and Wales appeared unlikely to be able to deliver the policy line favoured by the UK government. None of the early cases involved health or healthcare policies, and so far any cracks seem to have been papered over satisfactorily. But the potential for future difficulties remains.

In all three of the new administrations, the design of ministerial portfolios has involved combining responsibilities for health and personal social services, sometimes with other responsibilities added. The emphasis on delivering 'joined up thinking' in government is very apparent.

As the country reports below will reveal, the degree to which health featured in the three election campaigns differed. In Northern Ireland, it is reported, in some of the manifestos it received hardly a mention, and it did not feature prominently in public debate. In the Scottish and Welsh campaigns, health featured more prominently, although in general terms there were relatively few major policy differences in the manifesto commitments. The agendas favoured by the Nationalist parties, the Scottish National Party and Plaid Cymru, were the exception, implying considerably more radical changes to current arrangements.

Devolution brings both new politics and new politicians. In the six months that the Scottish Parliament and National Assembly for Wales have been in existence, some of the key features of the changes have started to become apparent. The first is the very steep learning curve faced by some of the new politicians and especially the ministers. Neither of the

Health Secretaries has previous experience as national politicians. The Scottish Minister for Health and Community Care, Susan Deacon, has worked as a business consultant and at senior levels of local government and higher education. The Welsh Health and Social Services Secretary, Jane Hutt, has local government experience and has served as a non-executive director of an NHS community trust.

The political processes in the Parliament and Assembly are also new, and there is learning here too. The precise nature of the relationship between the Executives and the Committees of the Parliament or Assembly is still to be resolved, and in particular the locus of the committees in the policy formation and scrutiny process is yet to be determined. Already, in health, a vigorous dynamic is developing around, in Scotland, the work of the Health and Community Care Committee of the Parliament and, in Wales, that of the Health and Social Services Committee. It is too early to say whether the fears noted in our first report, that the new bodies and their members might bring about an explosion of audit and scrutiny rather than the development of strategic leadership, were justified. The next year or so may start to cast light on this.

Another and very recognisable innovation is the commitment in the new administrations to a transparent process of government. The openness of the systems and rapid publication of, and access to, information is leading rapidly to the establishment of very distinct cultures and processes of government, which are profoundly different from that which pertains in Whitehall. One consequence already becoming apparent is that the openness and inclusiveness of the processes in Cardiff and Edinburgh can also make them slower than those in London. At times this is causing problems for inter-governmental transactions.

From these general comments, we now turn to the individual country reports, in which there are specific issues worthy of comment.

In **Northern Ireland** there are three issues which are peculiar to that country's situation. First is the long-standing administrative integration of health and social services, exemplified by the four Health and Social Service Boards established in 1973 - an early gesture towards 'joined-up government'. Second is the relative poverty of thought about health issues on the part of the main political parties. As devolution 'goes live' the health services are in the middle of implementing some controversial restructuring policies developed under the previous system of administrative devolution. How to cope with this will be an early test of the new politics, and a widespread concern among health professionals is that the result may be a period of stalemate and stagnation, thus slowing down necessary change. The third special feature is the extent of administrative co-operation already existing across national boundaries between departments in Northern Ireland and the Irish Republic, which will be strengthened by the establishment of a number of new North-South bodies.

The report from our partners in **Wales** also singles out three issues or 'themes' which will continue to preoccupy the new National Assembly and the administration for some time to come. These are, first, pressures on the budget, exacerbated by deficits accumulated by Welsh health authorities and trusts over recent years. The second is the need for investment in the technical modernisation of health provision, which is hard to reconcile with the current structure and distribution of care services. The third is the perceived need to reorganise primary care in Wales. Also notable is the recent study, summarised in the report, of the organisation of NHS Wales, which has already resulted in some substantial changes.

One distinctive feature of the situation facing the new government in **Scotland** is the tax-raising powers given to the Scottish Parliament. These could, in principle, be used to raise the budget of the NHS in Scotland. One significant early development is the commitment, already declared by the Executive, to an 'holistic' and inter-organisational approach to public health. A further potentially important influence on future policy is the 'Arbuthnott' report, published in July 1999, on allocation of NHS resources. On the one hand this has proposed some significant changes in the allocation formula, with the aim of achieving greater equity. On the other, the proposed new allocation method has been criticised by the Parliament's Health and Community Care Committee for failing to meet the Government's own commitment to transparency, and for being little less opaque to citizens than its predecessor. Future debates on this point in particular will be central to the themes of this project.

Northern Ireland

Introduction

Since the 1997 general election, the preparation and outworking of the Belfast agreement of April 1998 have dominated the political agenda in Northern Ireland. The continuing predominance of constitutional and other controversial issues—overshadowing debate on health and other potentially devolved matters during the Assembly election of June 1998 - delayed the transfer of power to the Stormont Assembly. The mood of optimism fed by the agreement became one of mounting resignation.

Party thinking on a number of strategic proposals by government is thus underdeveloped. The nascent Assembly and the relevant minister are, for instance, confronted by proposals for major reform of the health and social services and the associated organisational arrangements, as well as specific propositions for the rationalisation of acute hospital services - a matter on which the Assembly did hold a 'take note' debate last year.

Health professionals are increasingly frustrated by the delays in implementation, caused by the wider political impasse. And, while generally supportive of the devolution scheme, they are concerned that, although powers have now been transferred, there could be further delay; the Minister and the relevant Assembly committee might be tempted to embark on a further round of consultations, especially on the vexed hospitals issue.

Below we address party policies on health and social care, questions of finance, and the thinking behind a number of official documents. We look at the very limited steps which were taken to prepare for devolution, where Northern Ireland obviously lagged seriously behind Scotland and Wales. And we also address a special dimension of devolution to Northern Ireland - the north-south relationship in Ireland. We also present a brief description of some of the inequalities in health in the region and discuss the core programme 'targeting health and social need' (THSN) designed to tackle them. But first we describe the pre-devolution structures of health (and social services) governance.

Structures

The current structures predate direct rule. Their administrative roots lie in part in the Cameron Commission report into the disturbances of 1968¹, which concluded inter alia that

¹ Cmd 532: Cameron Report: *Disturbances in Northern Ireland: Report of the Commission appointed by the Governor of Northern Ireland* (HMSO: Belfast, 1969). A bibliography for Northern Ireland can be found at Annexe 1 to this report.

Catholic grievances over the gerrymandering of electoral boundaries and of discrimination in housing allocations by local authorities had 'a substantial foundation in fact'. These findings had a profound effect on local government in Northern Ireland, reform of which was accelerated by the serious civil disorders of August 1969, occasioning the despatch of British troops to the region.

In October 1969 an expanded housing programme and a new central housing authority - the Northern Ireland Housing Executive - were announced, which had implications for other local-government services, including water, roads, recreational amenities and the staffing of councils. With the social services already the subject of review, a further review was undertaken of local government, its brief to advise on the most efficient distribution of all the relevant functions of local authorities in Northern Ireland. Chaired by Patrick Macrory, and with equal Protestant and Catholic membership, the committee reported in June 1970². It recommended that the functions be divided into two main categories: regional services requiring large administrative units, and district functions administered through smaller units. Predicated on the assumption of Stormont's survival, the Macrory report recommended that the Northern Ireland parliament should assume responsibility for regional services, including health and social services.

The goal of the report, which led to a streamlined structure of 26 district councils with greatly diminished functional responsibilities, was the creation of a professionalised system of service delivery. To that end it proposed that health and social services (and education) should be administered through a system of 'area boards' (four in the case of health and social services and five for education). The boards were to be composed of experts in the relevant fields, appointed by the responsible minister, together with a minority of local council representatives. However, the fall of Stormont and the introduction of direct rule in 1972 meant that the power of appointment to the boards lay with the newly created post of Secretary of State.

The four H&SS boards - Eastern, Western, Northern and Southern - have remained intact since 1973, although their composition has been altered. The representation of councillors was removed in 1991 and they currently comprise executive and non-executive Directors (the Western board, for instance, has four of the former and seven of the latter), each appointed by the Secretary of State.

Also in 1991, four Health and Social Service Councils were established, to act as watchdogs over the boards. Membership of the Councils is constituted thus: 40 per cent of their places are reserved for district councillors, appointed by the DHSS in consultation with the relevant councils (in the case of the Western board these are Limavady, Derry City, Strabane, Omagh

² Cmd 546: *The Review Body on Local Government in Northern Ireland* (HMSO: Belfast, 1970)

and Fermanagh); 30 per cent are appointed by the Department as individuals representing voluntary organisations and community groups; and the remaining 30 per cent are those considered by the DHSS to have an interest in the provision of health and social services. The duties of the Councils are to represent the views and interests of the public, to keep the operation of all health and social services in the board area under review and to recommend improvements to them. It is to this system of health and social services governance that *Fit for the Future* (see below) is addressed, envisaging as it does the demise of the area boards and the system of patronage upon which they and the H&SS councils is based.

After some chopping and changing in the first decade of direct rule, Northern Ireland settled down to the six government departments prevailing in 1999: Agriculture, Finance and Personnel, Education, Environment, Economic Development, and Health and Social Services. The local integration of health and personal social services is unique in the UK - elsewhere, social services being a discrete function of local government - though there is professional scepticism as to how much this integration is reflected on the ground. The department also has responsibility for social security (there being no separate department to that effect), for child support and for three non-departmental public bodies: the Mental Health Commission for Northern Ireland, the National Board for Nursing, Midwifery and Health Visiting for Northern Ireland, and the Northern Ireland Council for Postgraduate Medical and Dental Education.³

The DHSS administers four main areas of 'business', viz., health and personal social services, including hospitals, family practitioner services, community health and personal social services; social security; child support; and social and charities legislation. The aim of the Department is not merely to develop its programmes in parity with Great Britain but to build them into an interlocking and mutually supportive system of health and social care, allied to income maintenance for the needy and vulnerable.

Health and Personal Social Services is organised into a number of groups and agencies: the Health and Social Policy Group, which sets overall strategy for health and social policies, including cross-departmental issues; the Health and Social Services Executive, responsible for allocating resources and ensuring they are used efficiently, effectively, economically and in line with standards of public accountability; Professional Groups - Medical and Allied Services, Nursing and Midwifery, Pharmacy, Dental and the Social Services Inspectorate - which provide direct advice and support to the HSS Executive and the Policy and Strategy Group; HPSS delivery organisations, i.e. the four Area Boards, Health and Social Services Trusts and Health and Social Services Agencies which provide specialist services for the Department, including the Central Services Agency, Health Promotion Agency and the Guardian ad Litem Agency; and the Health Estates Agency which provides a range of estate

³ *Northern Ireland Executive Non-Departmental Public Bodies 1998 Report*, p.89 (HMSO, 1999)

services to clients across the health and social services sector. The Health Estates Agency is one of the Department's three 'next steps' agencies, the others being the Social Security Agency and the Child Support Agency.

The Department employs over 8,000 staff, the majority of whom – around 5,000 – work in the Social Security Agency. Its net public expenditure for the 1998/99 financial year amounted to £5,120m, representing more than half of total public expenditure in NI Departments. Total planned expenditure on the health and social services programme in 1998/99 amounted to £1,710m, sub-divided into three broad areas: hospital, community and personal social services; family health services; and centrally financed services.

Tackling Inequalities in Health: THSN

The Permanent Secretary of the DHSS has admitted that, "inequalities in health remain and, if anything, are worsening"⁴. THSN was introduced to Northern Ireland in the third Regional Strategy for Health and Wellbeing (1992) covering the period 1992-97. It represented the DHSS's version of 'targeting social need' (TSN), the wider, long-term programme announced by Peter Brooke in 1991 designed, "to bring about fundamental change in Northern Ireland society".

The parent programme was described by Brooke as the Government's, "third public expenditure priority", following 'law and order' and 'strengthening the economy'. However, as Quirk and McLaughlin observe,⁵ TSN suffered from an initial lack of clarity: "[I]t is a principle awaiting definition, operationalisation and implementation". Although THSN was adopted by the DHSS in 1992, it was two years before the four Health and Social Service Boards established a working group within the Department, whose brief included guidance on its application. It was not until the appearance of the fourth regional strategy⁶ that such guidance became explicit.

Together with the current regional strategy, *Well into 2000*⁷ provides the policy framework over the period 1997-2002 and sets out the government's strategy for tackling health inequalities. Describing THSN as an 'essential component' of all the department's policies and programmes, it sets out a three-stranded approach: developing and implementing inter-agency strategies; improving access to health and social programmes; and encouraging full participation by individuals and communities in tackling identified inequalities. Among the

⁴ Gowdy, C. 'Tackling health inequalities', *Promoting Health* (journal of the Health Promotion Agency for Northern Ireland), issue 5, March 1999

⁵ Quirk, P. and McLaughlin, E. 'Targeting Social Need', in McLaughlin and Quirk (eds.) *Policy Aspects of Employment Equality in Northern Ireland* (Belfast: SACHR, 1996)

⁶ *Health and Wellbeing: Into the Next Millennium* (Belfast: DHSS, 1997)

⁷ *Well into 2000: A Positive Agenda for Health and Wellbeing* (Belfast: DHSS, 1997)

latter, *Well into 2000* reports:

- the infant mortality rate (7.1 per 1000 live births in 1995) is the highest in the UK;
- children born into families whose head is skilled, semi-skilled or unskilled have a 20 per cent higher mortality rate in the first year than those whose head is in the professional or managerial groups;
- life expectancy (72.9 years for men and 78.4 for women) is less than the European average;
- among men of working age, mortality is three times greater for those in the unskilled than in the professional group;
- the rate of early death from coronary heart disease is one of the highest in the EU (94 per cent above the EU rate for men and 173 per cent for women).

Further details on mortality and morbidity in Northern Ireland can be found in Northern Ireland Statistics and Research Agency (NISRA) and Campbell⁸. Data on the performance indicators government has designated for the health service itself - waiting times, etc. - were published in 1999.⁹

Following *Well into 2000*, the department consulted on a regional 'action plan' to support and co-ordinate THSN - including on targeting resources and services where needs are greatest; how community approaches might be best used; and how progress should be monitored and evaluated¹⁰. A steering group was established in the department to advise on the specific actions.

The governing principle of THSN is that resources are directed to those most in need. To that end, a review group within the department's health and social services executive recently recommended a revised formula for allocating funds within the four area boards, to take account of social needs in each board area. The executive requires the boards to demonstrate shifts in the allocation of resources across and by trusts to improve equity. The strategic objectives of the management plan are:

- tackling inequalities through the THSN initiative;
- promoting health and social well-being;
- developing primary and community care;
- improving acute hospital services, and;
- securing maximum health and social gain for the population from available

⁸ Campbell, H. *The Health of the Public in Northern Ireland: Report of the Chief Medical Officer* (Stationery Office, 1999)

⁹ *The Northern Ireland Health and Personal Social Services Performance Tables for 1998-1999: The Charter for Patients and Clients* (Belfast: DHSS, 1999)

¹⁰ *HPSS Management Plan 1999/00-2001/2002* (Belfast: DHSS, 1998)

resources.

Within these terms, the management plan sets out the THSN priorities for the boards. They will draw up implementation plans for achieving THSN objectives; identify, implement and evaluate interventions to reduce inequalities; and evaluate their programmes and services to ensure targeted resources are reducing inequalities. At a conference in Belfast in September 1999 ('Better Health and Social Wellbeing'), to highlight the health (and social services) priorities for the Assembly, the current minister, George Howarth, drove the message home. If they needed to be, local politicians were reminded "that the indicators of health status in Northern Ireland point up that the health of the population is much poorer than it should be".

Howarth pushed them heftily towards policy maintenance by asserting: "Initiatives which are already in place to tackle inequalities in health", including THSN, "will need to be continued" and commended the existing cross-departmental approach to overcoming inequality. Anticipating inter-departmental struggles over budgets, he advised any new minister in a devolved administration to enlist the support of colleagues to ensure both policy coherence and allocation of sufficient resources, so as to achieve a lasting impact on public health and inequality.

Howarth also advocated the retention of 'health action zones' (HAZs) which, under the aegis of THSN, have been introduced to tackle inequalities locally. Northern Ireland's first HAZs - in north and west Belfast and Armagh and Dungannon - were established in February 1999, following their phased introduction in England. This model is designed, in the words of Howarth's immediate predecessor, John McFall, "to encourage and develop innovative ways to address the causes of ill health, and to reduce health inequalities in areas of greatest need". Funded initially for three years (£150,000 each in the first year), their purpose is to forge partnerships among statutory, private, voluntary and community bodies, towards an agreed strategy for improving the health of communities.

Notwithstanding TSN's rather inchoate start, in July 1998 it was relaunched as 'new' TSN, and was linked to a new objective of 'promoting social inclusion'. This will provide strategic guidance, if not direction, for any new health minister. So we turn to an outline of the parties' policies.

Party policies

As indicated, health - like other matters - was eclipsed during the Assembly election. Perhaps the clearest example is provided by the Democratic Unionist Party, one of the four components of the Executive Committee (cabinet). The DUP manifesto was almost wholly dedicated to an assault on the agreement, devoting just two sentences to health: "We are

committed to looking after your interests in a caring health service, responsive to local needs. We are pledged to providing health care free to all.”

The UUP’s manifesto devoted a page to health, rehearsing - in common with other parties - the need for increased resources for the NHS. It expressed concern about the concentration of acute services in six major hospitals, observing elliptically that, “hospitals appropriate to the needs of the local community [should] be provided away from the main centres”. It called for greater funding for domiciliary and respite care, together with better facilities for residential and nursing care for the elderly and those with special needs. It expressed concern about the growing rate of asthma among the young, welcomed recent increased support for the ambulance service and new developments in cancer treatment, and called for more staff to be recruited to the ‘Cinderella professions’ of speech and occupational therapy. There was some recognition of the need for a joined-up approach in its call for improved rural housing and greater efforts to tackle environmental pollution. In some implied respects the UUP’s approach was consistent with Government policy but, unlike the Social Democratic and Labour Party and Sinn Féin, a wider approach to tackling social inequalities was absent.

The SDLP’s manifesto declared: “Real health and social gain can only be achieved by reducing poverty and equality”, and observed that “there are major inequalities in health and care between social classes and a link between the prevention of ill health, income, education and housing.” Voicing the familiar complaint of NHS underfunding, it favoured delayering health and social services ‘bureaucracy’ and a ‘common services agency’ to provide integrated acute and community services.

In common with Sinn Féin, the SDLP supported equal and effective access to health and care services throughout Northern Ireland; both laid emphasis on prevention. Each opposed the internal market - the SDLP supporting its radical overhaul and the development of 3-5 year commissioning plans, Sinn Féin favouring an end to ‘opting out’ and the placing of cash limits on doctors. They also shared the demand for the ‘proper resourcing’ of carers, Sinn Féin singling out community carers and home helps and the SDLP advocating separate needs assessments for informal carers. With regard to the proposed reform of the hospital system, Sinn Féin opposed the removal of acute services from the Mid-Ulster and South Tyrone hospitals - each located in constituencies where it has considerable electoral strength.

Like the DUP, the other anti-agreement unionists elected to the Assembly (five UK Unionists and three independents) dedicated their election literature entirely to constitutional matters. The remaining pro-agreement unionist grouping, the Progressive Unionist Party, did however devote a section of its manifesto to health and social services. Beyond support for a ‘strengthening of the Health Service’ and the ‘proper funding’ of community care, and the ‘demand’ that patient care “is based on medical prognosis not profit motivation”, the gist

was an assault on 'the contract culture' fostered by the 'New Right'.

The health policies of the Northern Ireland Women's Coalition were built around its principles of human rights, inclusion and equality; references to health per se were scattered throughout its manifesto. It advocated a new Department for Environmental Protection and Public Health, to bring together responsibility for assessing the health impact of all government policies, and supported a budgetary emphasis on equality and social welfare and TSN. It advocated a Ministry for Children and Families, through which support services - including publicly-funded childcare and improved services for the elderly - would be administered. In a separate 'young people's manifesto', it called for the health needs of the young to be "addressed in a realistic way" via improved health education and for extended counselling services for those "faced with bereavement and trauma" associated with the conflict.

The party which conveys the clearest grip on existing and proposed health policy is Alliance. While health was absent from its Assembly manifesto, it has recently produced *A Healthier Tomorrow*, which shows a close familiarity with government proposals. It refers explicitly to the current regional strategy, calling for its full implementation, and - alone of the parties - advocates north-south co-operation on health, including in food safety, training, equipment and services, especially in border areas. It endorses local commissioning groups of GPs (currently piloting in five areas of Northern Ireland as 'primary care commissioning') and supports 'adequate and effective funding' for community care, 'targeted according to need'. It also favours longer term contracts for trusts, improved respite care and benefits for carers, improved health education and extension of the Patient's Charter to private nursing and residential homes.

On hospital services, Alliance proposes promoting of district general hospitals as 'centres of excellence', servicing and supported by community hospitals. It backs the further development of a cancer centre and local cancer units, based on the Campbell report¹¹ (1996). Unique among the parties, it proposes abolition of the area boards and their replacement by a single regional board accountable to the planned health and social services committee of the Assembly.

With the exception of Alliance, which has devoted some post-agreement effort to its thinking, the parties have produced either no or only rudimentary ideas for the future of the health service and related matters. Given the exposure of Assembly members to a wide range of advice and expertise from subject specialists, including health and social care professionals, via the 'transition programme' sponsored by the Northern Ireland Office, beginning in July 1998, this is somewhat surprising. The party spokespersons on health¹²

¹¹ *Investing for the Future: Report of the Cancer Working Group* (Campbell Report) (Belfast: DHSS, 1996)

¹² These are: Betty Campbell (Alliance), Iris Robinson (DUP), Norman Boyd (NIUP), Monica

seem to have made little demonstrable effort to come to terms with the current agenda. A series of 'heart of government' briefings was similarly organised for the first and deputy first ministers (designate) but this has yet to yield even a skeletal 'programme for government'.

One potential risk of the lack of progress on the programme is the 'capture' of ministers by their departmental officials. Conversely, though, a determination by a health minister to make a mark - which would rely on support from the Assembly committee as well as other ministers - could merely delay the implementation of existing proposals, in particular *Fit for the Future* and *Putting it Right*. It is to these documents that we now turn.

Fit for the Future

On April 30th 1998, less than three weeks after the Belfast agreement, the government produced its consultation document on the future of the health and personal services.¹³ In essence, *Fit for the Future* proposed a single, integrated service, centred on primary care, directed by and accountable to the new Assembly. In response to the consultation, in March 1999 the government produced its vision of the future, although it was careful not to represent it as a blueprint - rather, signalling the direction in which it wished to move. As McFall, the then minister, noted in his foreword, "it will be for the Assembly to take final decisions on the way forward".

The government set out six key themes in its response to the consultation:

- ensuring that the Assembly is able to exercise direct strategic control of the HPSS;
- placing an emphasis on improving the quality of services;
- ensuring fair access to high quality services to all;
- giving primary-care professionals control over how services are planned, funded and delivered;
- maximising the benefits of an integrated system of health and social care; and
- reducing bureaucracy.

The government envisages a two-phase programme of change. In the first, the GP fundholding scheme is to be abolished (this would require primary legislation) and 'primary care co-operatives' (PCCs) set up. The boards would continue to exist to facilitate the establishment of the PCCs, overseen and implemented by the proposed Department of Health, Social Services and Public Safety. The PCCs would develop to the point at which they would hold budgets and be responsible for commissioning most health and social

McWilliams (Women's Coalition), Dugald McCullough (PUP), Francie Molloy (Sinn Féin), Sam Foster (UUP), Joe Hendron (SDLP). Campbell and McCullough are not assembly members.

¹³ *Fit for the Future: A Consultation Document on the Government's Proposals for the future of the Health and Personal Social Services in Northern Ireland* (Belfast: DHSS, 1998)

services. This phase - anticipated by the government to last two to three years - would also see the reconfiguration of trusts (requiring secondary legislation). In the second phase, the boards would be abolished, with the PCCs coming together to form 'health and social care partnerships' (again requiring primary legislation). In the government's view, the Assembly could accomplish this wholesale reform within four years.

As *Fit for the Future* put it, the proposals "provide the Assembly with a challenging and exciting agenda", offering "a unique opportunity for local politicians to guide and shape the future development of the HPSS". To date, there has been no considered response to the paper from the parties.

Putting It Right

By contrast, the government's proposals for reform of the hospital service, set out in November 1998, have attracted widespread comment, discussion - and opposition - throughout the region, including from the parties. Based on the premise that hospital services are facing a crisis, *Putting it Right*¹⁴ sets out four options for the future: maintain the status quo, expand services at all existing hospitals, concentrate services, or develop new care networks based on existing hospitals.

Currently there are 17 acute hospitals in Northern Ireland serving populations ranging from 60,000 to 250,000 (typically district general hospitals in England serve populations of between 250-300,000). This means that the vast majority of the population live within 30 minutes of a hospital providing some form of emergency care, while in general no one has to travel more than one hour to reach a hospital. However, in surveying the options for future provision, the government ruled out maintenance of the status quo because, while providing high accessibility, it is failing to deliver quality of care to patients. The department argued in *Putting it Right* (over which there was precious little public consultation) that medical staff working in smaller hospitals treat too few patients with too narrow a range of illnesses and are consequently unable to acquire or maintain skills. It noted, for example, that in 1997 three hospitals lost their training recognition for specialist registrars in surgery, precisely because they did not treat enough patients or illnesses. It also pointed out that in some cases vacancies for surgeons are filled by long-term locums who have not completed their higher surgical training, and that "too many" accident and emergency departments are not properly staffed or equipped. In short, the status quo "does not deliver quality of care".

The option of expanding the existing 17 hospitals was also rejected on the ground that it would mean "spending more to buy less", because smaller hospitals would be "seriously

¹⁴ *Putting it Right: The Case for Change in Northern Ireland's Hospital Service* (Belfast: DHSS, 1998)

over-staffed for the volume of work they do". Another alternative, that of concentrating acute provision to serve larger populations of between 450-500,000, was rejected because it would mean there would be only three major hospitals in the region - two in Belfast and one in Derry - thereby seriously disadvantaging rural populations. Moreover, many seriously ill people would have increased travelling times: the government calculated that as many as one in five of the population would be more than an hour away from a major hospital.

These three options having been dismissed on the grounds - respectively - of inadequacy, inefficiency and inaccessibility to patients, the preferred approach was one whereby 'partnerships of care' between hospitals and 'primary care teams' (PCTs) would be established. The latter would provide most health care, with access to one of 12 local hospitals, some of which (the proposals suggest four) would offer a general acute service. Area hospitals would provide a wide range of specialities, including a consultant-led accident-and-emergency service, designated cancer units, surgery, orthopaedics, paediatrics, obstetrics and gynaecology. *Putting it Right* identified four area hospitals, complemented by the Royal Group and the City, which would provide area services in greater Belfast. The regional hospitals - the Royal Group and the City - would provide specialist care to the whole population, including neurosurgery, paediatric neurology, children's cancers, heart and chest surgery, cystic fibrosis and regional trauma care; they would also act as centres for medical research and training.

During the take-note debate in the Assembly on 14 December 1998 - there was also a debate at Westminster in the Northern Ireland Grand Committee in January 1999, the only occasion the latter body has debated health matters - Mr McFall set out the case for change, urging members that it was essential to supply "a first-class service". He sought to reassure them that the proposed reform was not cost-cutting, nor would it entail closure of any hospital. However, members from all parties - especially those representing the more rural areas - engaged in special pleadings for the retention of services in hospitals in their constituencies. (This yielded some interesting tactical coalitions among unionist and nationalist members from west of the Bann.) Against the background of continuing public protests against the removal of services from hospitals throughout the region, the assembly will face difficult decisions if ever empowered to take them.

Preparing for government

The Northern Ireland Act of November 1998 translated the Belfast agreement into legislation, including provision for a Northern Ireland Assembly and an Executive Committee of ministers. It did not stipulate the number of departments, but it provided for the appointment of ministers through application of the d'Hondt proportionality rule. The 108-member Assembly had, indeed, already been elected in June, one of its first acts being the joint election of David Trimble, the Ulster Unionist leader, and Seamus Mallon, deputy

leader of the Social Democratic and Labour Party, as respectively first and deputy first minister (designate).

On 18 December, after protracted negotiations between the parties, Trimble and Mallon agreed that the number of departments would be increased to ten¹⁵. Despite this proliferation (essentially a piece of *Realpolitik* to ensure Sinn Féin would have two seats on the executive), it was not envisaged that health and social services would be split up. On the contrary, the proposal was to rename the department as of Health, Social Services and Public Safety - its brief including public health and safety, and health promotion. (The department would also acquire responsibility for another NDPB, the Fire Authority for Northern Ireland.)¹⁶

A new health minister would not, of course, start with a *tabula rasa*. Leaving aside social security and child support, the department defines its 'key supporting aims and objectives' thus:¹⁷

To improve the health and wellbeing of the people of Northern Ireland:

- by promoting policies which lead to good health and wellbeing and reduce preventable disease, disability and ill-health;
- by minimising inequalities in population health and wellbeing and in the need for, and access to, care services;
- by ensuring that effective health and social care services are available to all.

The first of these aims was addressed in the document published within months of Labour's arrival in power, *Well into 2000*, which highlighted the high rates of mortality in Northern Ireland and was discussed above. *Well into 2000* signalled that a 'ministerial group on public health' would be established, bringing together senior representatives of all departments under the lead of the health minister - one result being the two HAZs referred to above. How the Executive Committee responds to these underlying public-health problems - as against dealing with day-to-day crisis-management especially with regard to acute provision - will be a big test of the success of devolution. The renaming of the department, and in particular the references to public health and health promotion, would appear to prefigure a strong emphasis on public-health outcomes and prevention of illness, rather than

¹⁵ These were: Agriculture and Rural Development; Culture, Arts and Leisure; Education; Higher and Further Education, Training and Employment; Enterprise, Trade and Development; Environment; Finance and Personnel; Health, Social Services and Public Safety; Regional Development; and Social Development.

¹⁶ *Report from the First Minister (Designate) and Deputy First Minister (Designate)* no. NNIA 7, 15 February (New Northern Ireland Assembly, 1999)

¹⁷ *Northern Ireland Expenditure Plans and Priorities: The Government's Expenditure Plans 1999-2000 to 2001-2002* (Department of Finance and Personnel/HM Treasury, 1999)

simply on service delivery. An early indicator would be a willingness to appoint a junior minister for public health.

In late 1998, the permanent secretaries of the six existing departments provided the offices of the first and deputy first minister designate with documents, consisting in each case of a few A4 pages, on existing strategic priorities. These had been requested with a view to informing the programme for government which the Executive Committee is required by the Northern Ireland Act 1998 to agree. The DHSS identified eight 'main agenda items' for the executive. As regards health and social services these were:

- development of public health strategies;
- childcare strategy;
- food safety;
- acute hospital reorganisation;
- *Fit for the Future*, and
- improvements in social services.

Of the three specifically health items, the first was detailed as:

The development of a rolling programme of strategies to cover the health and wellbeing of children and young people; the prevention of home accidents; the promotion of physical activity; workplace health promotion; and food and nutrition - activity will continue throughout the next three years.

The involvement of the department in childcare (along with the department of education) is potentially helpful in this regard, but in lieu of devolution direct-rule ministers went ahead and published a childcare strategy document in September 1999¹⁸. On food safety, the department wanted the Executive Committee to consider whether Northern Ireland should have its own agency or feed into a UK-wide or north-south agency. In the absence of devolution the first of these options went by default; in their December 1998 agreement, the first and deputy first ministers agreed that a north-south 'implementation body' on food safety would be established (see below), and in January 1999 the British government began the legislative process to establish a UK Food Standards Agency. On *Fit for the Future*, the department said key policy decisions were:

- the development of strategies on quality, human resources and information technology;
- organisational arrangements, including the development of new primary care-centred local commissioning arrangements following the abolition of GP fundholding from April 2000.

¹⁸ *Childcare First: The Northern Ireland Childcare Strategy* (Belfast: DHSS/Department of Education for Northern Ireland, 1999)

But the most controversial item on the list was clearly acute hospital reorganisation. The d'Hondt system for appointing ministers to the Executive Committee required parties to establish pecking-order preferences for departments, determining which in turn they would choose as the formula unfolded. It was very clear that the parties saw the health portfolio as a poisoned chalice, aware as they all were of the unpopular decisions they might be called upon to make vis-à-vis hospital rationalisation. In a number of instances, 'save our hospital' campaigns have engendered intense feeling, organised around local identity, especially in areas in the south and west of the region which have traditionally felt neglected by Belfast (with an undertone of sectarian disadvantage). On this issue, the department diplomatically said: "The Executive Committee will have to decide over forthcoming months how best to implement recommendations that may be locally sensitive." It was no wonder that a document prepared for a 'brainstorming session' on the programme for government in January 1999 referred to the health brief as "likely to be the hottest political potato". In the event, the health portfolio was allocated to Sinn Féin, as was the education portfolio: Bairbre de Brun became the Minister for Health, Social Services and Public Safety.

The wariness of the parties towards the health portfolio, owing to the acute-hospital issue, may militate against a positive drive to address the underlying public-health problems of Northern Ireland. Indeed, the region's chief medical officer has written in iconoclastic vein about the potential of devolution in this regard:

Devolution brings real opportunity. We need an Assembly that recognises health as a basic human right and as a prerequisite for the sustainable development of Northern Ireland. Health is a matter of politics as much as personal practice, and when major inequalities in health exist then health is inescapably a matter for the Assembly. We need politicians with a comprehensive and co-ordinated commitment to improving health.¹⁹

North-south

Administrative co-operation between departments north and south in Ireland has been a growing feature of recent years²⁰. Indeed, the senior official in the Taoiseach's office responsible for Northern Ireland told one of the authors in September 1999 that in his estimation it had reached as high a level as was possible under existing arrangements. Health has been a prime area for such co-operation, with bilateral ministerial meetings giving a political lead. One result was the establishment at the end of 1997 of an all-Ireland Institute of Public Health. A north-south conference is held annually on health and safety at

¹⁹ *The Health of the Public in Northern Ireland: Report of the Chief Medical Officer* (HMSO, 1999)

²⁰ Fee, J. 'An Official View', in *No Frontiers: North-South Integration in Ireland* (Belfast: Democratic Dialogue, 1999) pp. 11-14

work. The Health Promotion Agency for Northern Ireland and the health promotion unit of the Department of Health and Children in the republic “have established a close working relationship”. A joint waste management body of officials from the two jurisdictions was established in 1995 to address clinical and healthcare-risk waste on an all-Ireland basis. And there is “co-operation on patient-centred cancer strategies”. At a more immediate cross-border level, two health and social services boards from the north and two health boards from the south, lying on either side of the border, have had a mutual arrangement since 1992 called ‘Co-operation and Working Together’.²¹

The December 1998 agreement between the first and deputy first minister designate included the designation of six ‘implementation bodies’ accountable to the North-South Ministerial Council envisaged by the agreement, as well as six areas for co-operation using existing structures²². Health was one of the latter, with the issues concerned identified as: accident and emergency planning, co-operation on high-technology equipment, cancer research and health promotion. As to the former, it was proposed that a food-safety body would be established, addressing:

- promotion of food safety;
- research into food safety;
- communication of food alerts;
- surveillance of food-borne diseases;
- promotion of scientific co-operation and linkages between laboratories;
- development of cost-effective facilities for specialised laboratory testing.

The implementation bodies were clearly envisaged as having executive functions (though the word ‘executive’ was avoided to assuage unionist sensitivities). This would imply a superordinate relationship to any existing agencies in either jurisdiction, or even the replacement of the latter by the all-Ireland structure. But the Food Safety Promotion Board, as it will be called, will not replace the Food Safety Authority in the republic (or the UK-wide Food Standards Agency in the north). The minister for health and children, Brian Cowen, told his northern counterpart, John McFall, in May that the joint body would merely complement those confined to one side of the Irish border²³.

²¹ Northern Ireland Office *Northern Ireland Executive Non-Departmental Public Bodies 1998 Report* (Stationery Office, 1999)

²² New Northern Ireland Assembly *Report from the First Minister (Designate) and Deputy First Minister (Designate)* no. NNIA 7, 15 February 1999

²³ ‘Northern and southern health ministers meet in Dublin’ (Belfast: Northern Ireland Information Service, 4 May 1999)

Finance

GDP per head in Northern Ireland is just over 81 per cent of the UK average. Despite the dampening intent behind the Barnett formula,²⁴ the allocation of public expenditure across the territories of the UK has continued to be highly beneficial to Northern Ireland since 1978. Reflecting the fact that public spending represents almost 60 per cent of gross domestic product, as against around 40 per cent for the UK as a whole, public expenditure per head is 33 per cent higher in the region than the UK average, even though tax paid per head is only 81 per cent of the UK mean.²⁵ The greater transparency of fiscal transfers associated with UK-wide devolution will militate against the maintenance of such largesse in the long run. But, meantime, in addition to external support from the European Union, Northern Ireland has benefited from the chancellor's special £315 million initiative for the region announced in May 1998 and from the comprehensive spending review (CSR) - owing to the prominence of the favoured health and education arenas within the Northern Ireland block.

In the current financial year (1999-2000), spending on health and social services comprises 19.5 per cent of the £9.5 billion Northern Ireland total. Indeed, when the detailed results for Northern Ireland of the CSR were announced in December 1998, it was evident that of the £1.4 billion allocated in July by the chancellor, Gordon Brown, to the region in the UK-wide process, over half (£732 million) was to go to health and social services over the three-year review period. This was claimed by government to represent a real-terms 3.8 per cent per annum increase, assuming that pay and price inflation would be managed within government's 2.6 per cent GDP deflator projection, which would absorb some £270 million of the additional cash over the same period. The then junior NIO minister Paul Murphy told the Northern Ireland Grand Committee that this would allow hospital waiting lists to be reduced below the level inherited from the previous government, provide an extra £74 million for community care for the frail and vulnerable, and allow £30 million more to be spent on childcare for children deemed at risk, again spread over the three years²⁶.

However, the picture for service development may not be so rosy. Internal health and

²⁴ Barnett, R. and Hutchinson, G. 'Public expenditure on the eve of devolution' pp. 48-70 and Heald, D. 'Fiscal opportunities' pp. 71-87, in Wilson, R. (ed.) *Hard Choices: Policy Autonomy and Priority-setting in Public Expenditure* (Belfast: Democratic Dialogue/Eastern Health and Social Services Board/Northern Ireland Economic Council, 1999)

²⁵ Travers, T. 'Will England put up with it?', *Guardian*, 21 April 1999

²⁶ 'Boost for health and education spending in Northern Ireland – Murphy' (Belfast: Northern Ireland Information Service, 10 December 1998). A detailed breakdown of envisaged expenditure within the DHSS over time is available in *Northern Ireland Expenditure Plans and Priorities: The Government's Expenditure Plans 1999-2000 to 2001-2002* p.233 (Department of Finance and Personnel/HM Treasury, 1999)

personal social services pay settlements in excess of inflation in 1999-2000 could absorb a further £60 million (over the three years). Similar levels of settlement in the independent care sector will reduce the services that can be commissioned, while the additional costs associated with provision over the millennium must also be recognised. Any further pay settlements in excess of projected inflation in years two and three of the review period will bear down correspondingly on service growth.

Conclusion

This survey of Northern Ireland post-agreement betrays a worrying lack of preparedness on the part of the principal political parties for the complex challenges that assuming responsibility for devolution in health entails. Denied access to power for over a quarter of a century, Northern Ireland's political class is unfamiliar with the underlying policy concerns in this field, as against concrete and tangible issues presented to them by local lobbyists. The maxim "all politics is local" could indeed have been coined for Northern Ireland, where, as in the republic, the political culture remains largely clientelistic. The combination of these factors has meant that debate on health has been disturbingly rare and, in as much as it has been evident, all too frequently reduced to local battles over acute hospitals. The document produced for the 'brainstorming session' on the programme for government in January 1999 was brutally frank:

Assembly members have up to now been in a 'permanent opposition mode'. They have not had to confront the hard decisions associated with priority-setting and resource allocation. The primary motivation of Assembly members will be to seek advantages for their particular constituencies rather than advancing the interests of the region as a whole.

As regards the Executive Committee it said: "The new Ministers and officials will be on a steep learning curve." Nowhere is this more so than in health.

Scotland

Introduction

Health policy and the organisation of the National Health Service north of the border has in the past differed to some extent from England within the broad framework of the United Kingdom's national health philosophy and structure. Organisationally, because Scotland is a smaller and some would argue a more cohesive country, the structure has been simpler and centred on the 15 Health Boards. In financial terms, spending on health per capita has been higher in Scotland than in the rest of the United Kingdom but the health of its population has been worse.

In 1997, a White Paper - *Designed to Care* - set out the proposed government changes to the structure of the health service in Scotland.²⁷ These came into force on 1 April 1999, shortly before the elections to the Scottish Parliament.²⁸ The main changes were to reduce the number of trusts in an effort to strengthen networking, facilitate strategic planning, and eliminate duplication of services and wasteful competition. Two types of trusts were established - Acute Hospital Trusts and Primary Care Trusts, responsible for all primary care, including community hospitals and mental health services.

The Scottish Parliament

On 6 May 1999, the people of Scotland went to the polls to elect their first Parliament in nearly 300 years and the country now has 129 MSPs and a Labour/Liberal Democrat Coalition Executive. While the Westminster Parliament retains power over major areas such as the constitution, defence, the economy and social security, among the powers devolved to the Scottish Parliament are health and social care.

The Scottish Executive (formerly the Scottish Office) consists of six main departments of which one is the Health Department (SEHD). The Management Executive of the NHS in Scotland, which is responsible for health policy and administration is headed by the Chief Executive, a senior civil servant who advises Ministers on national strategy, policy and performance assessment. There is within SEHD, a Chief Medical Officer and Deputy, a Public Health Policy Unit and a Chief Scientist whose Office funds, assesses and co-ordinates health-related research.

²⁷ *Designed to Care – Renewing the National Health Service in Scotland*. Cmnd 3811. (Edinburgh: The Stationery Office, 1997)

²⁸ *ibid.*

As well as its role in supporting and advising Ministers, the Management Executive has five other key responsibilities:

- to develop health service policy in Scotland while continuing to work closely with the Department of Health in London;
- to set national strategic directions as described in the annual Priorities and Planning Guidance it produces;
- to co-ordinate the work of the 15 health boards and encourage effective collaborative working;
- to manage the performance of the NHS in Scotland;
- to promote health leadership.

There is also a determination in Scotland, as in the rest of the United Kingdom, to assess performance in the following areas:

- *clinical effectiveness of services* - for example, in reducing mortality, morbidity and disability;
- *quality of services* - including waiting times for appointments for diagnosis and treatment;
- *efficiency of services*;
- *addressing inequalities in health* - in particular, differences in morbidity and mortality between socio-economic groups;
- *appropriateness of services* - such as the use made of day case surgery.

A number of other changes have been announced which include significant improvements in the use of information technology:

- The whole of the National Health Service in Scotland is to be linked to secure telecommunications systems and the use of telemedicine will be increased, making possible, for example, consultation with hospital specialists from a GP's surgery.
- In the next two years, use of the Community Health Index with an identifying number for every patient will be refined to facilitate the movement of individuals from general practice to hospital, ward to ward, and hospital to community and to improve the quality of patient data.
- One-stop clinics will be introduced to enable all relevant tests to be carried out on a single visit, with results and diagnosis, where possible, available on the same day.
- A Scottish Health Technology Assessment Centre (SHTAC) will be set up to provide guidance on the introduction of new technologies, including drugs.

The Responsible Minister is the Minister for Health and Community Care, currently Susan Deacon MSP, a former business consultant. She is responsible for health policy, the NHS in Scotland, community care and food safety. Her Deputy is Iain Gray MSP, the Minister for

Community Care.

The relevant Parliamentary committee is the Health and Community Care Committee which is chaired by a Liberal Democrat MSP, Margaret Smith, and is composed of the Chair and 10 other MSPs from all the main political persuasions represented within the Parliament (Annexe 4). Its remit is: "to consider and report on issues relating to the health policy and the National Health Service in Scotland and such other matters as fall within the responsibility of the Minister for Health and Community Care."

The Scottish Parliament and its Executive's commitment to a 'joined-up' approach to government and to health in particular is evidenced by the titles and remits of some of the other ministerial portfolios such as the Minister of Communities who has a junior minister for Social Inclusion. There are also a number of ministerial committees dealing with 'cross-cutting' themes, including drugs and sustainable development.

The Scottish Parliament has limited tax raising powers, not available to the Welsh Assembly, and therefore could, if it wished, use these to raise the NHS budget. The Labour Party's election manifesto, however, made clear that these powers would not be used during the first term of the Parliament and that has been confirmed in the coalition government's programme for the four year term of the parliament.

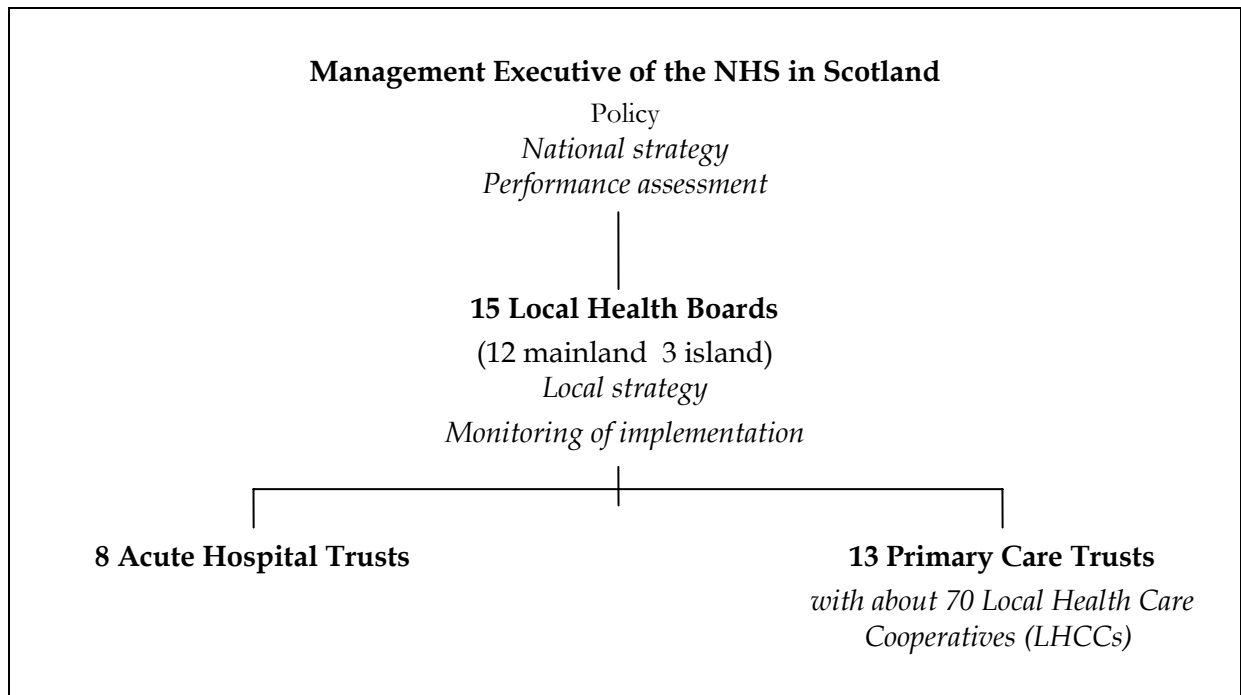
What is clear is that devolution has provided the opportunity within the United Kingdom for a "series of natural experiments in which the NHS model is adapted according to local preferences and circumstances. This creates real opportunities for the exchange of ideas and learning from the differences that emerge."²⁹

The present structure

The present structure of the NHS in Scotland is shown in Figure 1. The 15 Health Boards, which are listed, together with the Acute Hospital and Primary Care Trusts in each (Annexe 2) are accountable to the Scottish Executive and Parliament through the Management Executive. Chairmen of NHS Trusts, both Acute and Primary Care, are ex-officio members of their local Health Board, to emphasise the policy change from competition to collaboration.

²⁹ Ham, C. 'Variations on a theme: devolution and the NHS' *Health Services Management Centre Newsletter* 1999 5(3):2

Figure 1 : Structure of the NHS in Scotland



Acute and Primary Care Trusts are accountable to the relevant Health Board for the implementation of their Health Improvement Plans (HIPS) by means of their Trust Implementation Plans (TIPS). The Health Improvement Plans will aim to meet the long-term health needs of the people in each health board area, will be open to public scrutiny and will take account of national priorities for health improvement. The Trust Implementation Plans will set out for each local area, the changes in the pattern of services to be achieved, the resources that the boards intend to make available and the expected levels of services to be delivered. HIPS and TIPS are expected to have full involvement from all local agencies and local communities.

GP fundholding came to an end in Scotland when the NHS Bill received its Royal Assent at the end of June 1999. Voluntary networks of general practitioners have now been formed as Local Health Care Cooperatives (LHCCs) within the Primary Care Trusts and these now cover more than 95 per cent of the population.

One of the aims of these new provisions is to ensure that hospital and primary care services are more effectively integrated in the interests of better patient care whether in hospital or in the community. In support of this, health boards are charged with establishing a Joint Investment Fund (JIF) for the purpose of meeting priorities for health service improvements as identified by clinicians wherever they are.³⁰ Primary Care Trusts are intended to be the

³⁰ Ham, C. *Health Policy in Britain*. Fourth Edition. (Basingstoke: Macmillan Press, 1999)

main drivers of the JIFs.

In addition, in the pursuit of equal access to health care, a review has been carried out of the allocation of financial resources across Scotland (the Arbutnott Report - discussed in more detail below), and a single source of funds for hospital and community health services and drugs is proposed to allow Boards and Trusts more flexibility in meeting the needs of their local populations.

Strategic Direction

It is vital, in the context of the currently very poor health status of the Scottish population, that two distinct but complementary strands to the health service are recognised – *health care* which provides for those who are ill and *health improvement* which strives to produce better health at a population level. This is a concept that has been out of fashion for many years. As an eminent public health physician wrote more than 40 years ago:

everyone says that prevention is better than cure and hardly anyone acts as if he believes it, whether he is attached to Parliament, central or local government, or the commonality of citizens. Palliatives nearly always take precedence over prevention....Treatment – the attempt to cure the sick – is more tangible, more exciting, and more immediately rewarding than prevention.³¹

There is little doubt that the Scottish Executive does have health at the centre of its agenda. Health after all accounts for around one-third of the Scottish parliament's total budget and over half when finance to local authorities which is not under the detailed control of Parliament is excluded. And it would be a foolish First Minister who did not take seriously the responsibility for improving Scotland's depressingly poor health record. The highest risk of premature death in the European Union is clustered in the central belt of Scotland, the former German Democratic Republic (GDR) and Northern England.³²

It does seem that the Scottish Executive has recognised the importance of public health and health improvement. The 1998 Green Paper on Public Health - *Working Together for a Healthier Scotland* - articulated the government's commitment to improve health through action on life circumstances and lifestyles. In the White Paper - *Towards a Healthier Scotland* - which was published in February 1999, plans for improving health in Scotland were set out.

Scotland's record of ill-health remains a matter for serious concern and cries out for concerted action. Our position at or near the top of international league

³¹ Mackintosh, J.M. *Trends of Opinion about the Public Health* (London: Oxford University Press, 1953)

³² Stewart, S (ed.) *The Possible Scot*. (Edinburgh: Scottish Council Foundation, 1998)

tables of the major diseases of the developed world ... is unacceptable and largely preventable. Good health is more than not being ill: we need to work on a broad front to improve physical, mental and social well-being, fitness and quality of life.³³

There are three basic strands in Parliament's plans to improve health:

- a coherent attack on health inequalities based on a comprehensive and co-ordinated use of health and other resources and agencies capable of influencing health;
- a focused programme of initiatives aimed at improving and sustaining the health of children and young people;
- major initiatives aimed at the prevention of Scotland's two major killing diseases - cancer and coronary heart disease - each of which accounts for approximately a quarter of all deaths.

In terms of a holistic approach to health the government does seem to favour a cross-cutting approach and has pledged to provide clear leadership in the drive for improved health, working in close collaboration with the NHS, Confederation of Scottish Local Authorities, the CBI, the STUC, the Health and Safety Commission, the proposed new Food Standards Agency and the voluntary sector. It plans a public health strategy group led by the Minister for Health and Community Care and drawn from all Scottish Executive departments to ensure that policies and initiatives with health implications are properly integrated and co-ordinated.

A Review of the Public Health Function in Scotland, established by the Chief Medical Officer, reported in December 1999 and confirmed the important role of public health in championing, informing and measuring health improvement and to emphasise the need to optimise collaboration between academics, research scientists and NHS public health professionals.

Local government also has a profound influence on health improvement. Its role in the fields of housing, social work, education, transport, planning, leisure and recreation and police services affects peoples lives in every aspect and is central to any attempt to improve life circumstances and reduce existing inequalities and inequity. There must be improved relationships between health boards and local councils across Scotland. Good relationships already exist and work most effectively in some areas but remain less well established in others.

The political will appears to be there and the intentions seem good. But there is a tremendous challenge in trying to break down the existing 'boxes' of tradition,

³³ *Towards a Healthier Scotland. A White Paper on Health.* Cm 4269. (Edinburgh: The Stationery Office, 1999)

organisational control and budgets and in gaining acceptance from all sides that there is more to a National Health Service than illness. A need central to this objective is the establishment of a mechanism for *joint* accountability between health and social care. While this has not yet been achieved, work is reported to be underway to put such a mechanism in place.

Government Initiatives

The Government has planned a number of initiatives to help take their plans for health forward. Other agencies - such as the Scottish Royal Colleges, who have set up their own joint working group on Inequalities in Health, and the Scottish Consumer Council, which is working with the Scottish Association of Health Councils on public involvement in primary care - are also involved with a number of initiatives in their own particular fields of expertise.

Health Impact Assessment (HIA)

The Government is funding the Scottish Needs Assessment Programme to develop standard guidance on HIA using current work in pilot projects, such as the urban regeneration partnerships. The Public Health Strategy Group, led by the Health Minister, will promote the widespread use of HIA when formulating Government policies. All this will be reinforced by the creation of a chair in Health Promotion Policy, funded by the Health Education Board for Scotland, sited within the Department of Public Health in the University of Glasgow and shortly to be advertised. The same department will also be the site of a new Lindsay Chair in Health Policy, the details of which will be announced shortly.

Demonstration Projects

This has been described as the Government's flagship initiative in their attempt to improve the health profile of Scotland. £15 million is being made available to fund four demonstration projects, to be selected on the basis of bids from local interests:

- *Starting Well* will focus on the promotion of health and protection from harm in the period before birth and throughout the child's first five years.
- *Healthy Respect* will foster responsible sexual behaviour on the part of young people, especially in relation to teenage pregnancies and sexually transmitted disease.
- *The Heart of Scotland* will focus on the prevention of heart disease.
- *The Cancer Challenge* will add a screening programme for the early detection of colorectal cancer and take forward new measures to combat the carcinogenic effects of tobacco smoking.

Social Inclusion

There is an ambitious plan to tackle the problem of social exclusion with a Social Inclusion

Strategy to provide the framework for further co-ordinated action. In introducing the strategy First Minister Donald Dewar outlined the vision in the following terms:

Our vision is of a Scotland where everyone enjoys the benefits of prosperity, and where everyone has chances to work and to learn. A Scotland where everyone's contribution is valued and everyone can play their part in a modern, progressive democracy. A Scotland where those in difficulties are helped to get back on their feet, rather than being trapped in dependency or pushed further into the spiral of exclusion ³⁴

There are a large number of initiatives within the broad strategy - in community development through Social Inclusion Partnerships (SIPS) and in the areas of employment, education and housing. The strategy will be driven by the Social Inclusion Network which was set up in the summer of 1998 and includes representatives of Government and other national public and private sector organisations and individuals with grassroots experience of tackling social exclusion. The Network has three areas for priority action:

- Excluded young people
- Inclusive communities
- Impact of local anti-poverty action

Five Action Teams have been set up; three of these will cover the priority action areas, a fourth will prepare an Evaluation Framework to assess the success of the strategy and a fifth will explore barriers to 'making it happen'.

An Inclusion Plan was published in November 1999 - *Social Justice - A Scotland Where Everyone Matters*. The aim is to ensure integration of action at both a national and local level by pinpointing and addressing conflicts and gaps between programmes and to suggest new action arising from the recommendations from the three priority area action teams. It is clearly acknowledged that the Scotland of the vision will not be achieved overnight: "It will require a sustained effort over many years and the commitment of the whole community of Scotland. But with determination, imagination and a readiness to embrace real social change, it can be achieved."

³⁴ *Social Inclusion – opening the door to a better Scotland* (Edinburgh: The Scottish Office, 1999)

Allocation of resources

Fair Shares for All, the Report of the National Review of Resource Allocation for the NHS in Scotland, was published on 11 July 1999.³⁵ In the words of the Review's Chairman, Professor Sir John Arbuthnott, Principal of Strathclyde University:

It has sought to address some of the biggest questions for the Health Service in Scotland: How do we share out over £4 billion of public money per year? How do we measure the need for healthcare that exists around Scotland? How do we address through the distribution of resources the links between deprivation and ill health in seeking to tackle inequalities in health around the country?

The current distribution of money by the Health Department mainly to the NHS in Scotland, following the SHARE formula, in use for over 20 years, is as follows:

- Some 84 per cent (£4,166 million) is distributed as general revenue allocations to the 15 Health Boards. The Boards in turn fund Acute and Primary Care Trusts, and via them contract for primary care services with GPs, dentists, opticians and community pharmacists (none of whom are directly employed by the NHS in Scotland). Boards also agree the secondary, tertiary and community care services required from the NHS trusts.
- Some 3 per cent (£167 million) is either allocated centrally by the Department or distributed to the trusts for capital expenditure on estate and larger items of equipment.
- The remainder (about £602 million) is central allocations made direct by the Department under various budget heads such as the Scottish Ambulance Service, the Health Education Board for Scotland (HEBS), Nurse Education and Training, and the Common Services Agency.

The Arbuthnott Review was guided by:

- The need to achieve greater equity in the allocation of resources, by reflecting as precisely as possible the variation in health need across the country.
- The development of an allocation formula that is evidence based, that is sufficiently transparent to be made truly accountable, and that is practicable and delivers continuing stability for the health boards.

The report recommended a new resource allocation formula for health boards based on:

³⁵ *Fair Shares for All: Report of the National Review of Resource Allocation for the NHS in Scotland* (Arbuthnott Report) (Edinburgh: Scottish Executive, 1999)

1. The size of each health board population
2. An adjustment to account for age and sex
3. An adjustment to reflect the needs arising from ill health (morbidity) and life circumstances (e.g. deprivation, poverty and ethnicity)
4. An adjustment to reflect the unavoidable excess costs of delivering health care in rural and remote areas

Evidence that Scotland has more than its fair share of deprivation is provided in the report. Over 50 per cent of the population of Greater Glasgow Health Board fall within deprivation categories 6 and 7, in which category 1 is the most affluent and category 7 the most deprived. Tayside, Argyll and Clyde, and the Western Isles Health Boards each have between 16 and 50 per cent of their populations in categories 6 or 7. The Review concludes with a summary of the likely impact of its recommended formula on the distribution of Hospital and Community Services and GP prescribing expenditure.

Although it has been widely welcomed in an effort to tackle the current inequalities, the Review was limited in its terms of reference to *health care* and this has been seen as a major limitation. It is also concerned purely with resource allocation between Health Boards; equal attention must be paid to how resources are allocated within Health Board areas. The main deficiency of the methodology used is acknowledged in the report itself: “an approach based on past use of services may not adequately reflect the needs of more deprived communities, rural communities or minority ethnic groups”.

The Review also focused largely on inequalities in access to health care when a more important issue concerns inequalities in access to *effective* care. It calls for research on inequalities in health care to inform health policy and resource allocation but underestimates the difficulty of this, given the current lack of research capacity in deprived areas.

The Report of the Review was debated by the Health and Community Care Committee, which voiced some criticism of it³⁶. The Committee objected in particular to the difficulty of assessing both the methods used in the review and the resulting outcomes. The review “failed to satisfy its own criteria of transparency. The opaque methods limit understanding and informed opinion even by those with a knowledge of the Health Service.” The Committee concluded that “in view of the ongoing work that needs still to be done, the uncertainty of the data, and lack of confidence in fairer distribution across the board” implementation of the report should be delayed. The report has received a more positive welcome from the Executive, which is still considering it. Its clear achievement, despite the criticisms, is that it has opened up the agenda, drawn attention to the principles that should inform resource allocation and called for a more effective formula to be adopted. It is a good

³⁶ Health and Community Care Committee, 8th Report 1999 (SP paper 40)

beginning.

Future directions

A series of targets for all government departments were announced by the Government in September 1999 in the form of a document *Making it Work Together*.³⁷ For the Health and Community Care department these were as follows:

By the end of 1999:

- Scottish NHS Net will link all GP surgeries and hospitals, and will be extended to pharmacies thereafter;
- tobacco advertising will be banned;
- an Education, Training and Lifelong Learning Strategy for the NHS in Scotland will be published.

Neither of the first two objectives had been achieved by the end of the year, although the third had. The issue of tobacco advertising, in any case, raises UK-wide issues.

in 2000:

- a full report on Scotland's leading edge work on clinical outcomes and quality will be published;
- the Patients' Project - on communicating effectively with patients will be published;
- a Carers' Strategy to help unpaid carers will be published;
- the new Scottish Executive of the UK Food Standards Agency will be established.

by 2001:

- a Scottish Social Services Council will be established to regulate and improve the skills and standards of the social care workforce.

by 2002:

- an instant appointments system will be introduced so that people will know the details of their hospital appointment before they leave the local surgery;
- a network of Healthy Living Centres will be established, which will focus on improving health in areas of poverty and deprivation;
- a new generation of walk-in/walk-out hospitals will be provided with same day treatment.

³⁷ *Making it Work Together: Working together to build a healthy, caring Scotland*. (Edinburgh: Scottish Executive, 1999)

This is a formidable list of targets which, if achieved, will certainly begin to change the face of health across Scotland.

Conclusion

The political rhetoric is there, the structures to deliver are in place or being established, and the central importance of tackling inequalities has finally been fully acknowledged. What remains to be seen is how or whether, over the next few years, the rhetoric can begin to be translated into reality.

Wales

Introduction

The Welsh health and social services are confronting the National Assembly of Wales with its biggest managerial and administrative challenge. To begin with it takes by far and away the biggest slice of the budget, £2.7 billion or 34 per cent in 1999-2000 (see Table 4 in Annex 6). NHS Wales employs 65,000 staff and its impact on the economy is substantial. As important, so far as policy is concerned and as is the case across the developed world, the pressure on the NHS budget is inexorable and expectations are higher. Few other areas of the Assembly's activities are likely to prove as politically sensitive. Every Assembly member will have some health issue or other high on their agenda, whether it be a threatened hospital closure or declining emergency provision.

Added to all this the Assembly was immediately confronted with a serious spending deficit which threatens to destabilise future policies and expenditure plans. At the end of the financial year 1998-99 health authorities and Trusts in Wales had built up cumulative deficits of some £72 million. Of this, some £25 million was carried forward into the present financial year as a recurring deficit. This represents about 1 per cent of the total NHS budget. This position was so serious that it prompted the newly formed Policy Unit within the Welsh Office to undertake an analysis of the problem between April and June 1999. Their conclusions were published in July in a report entitled *Stocktake of NHS Wales*³⁸ which provided the newly elected Assembly members with a handy snapshot of their health service inheritance.

Background

Wales is a poorer country than much of the rest of the UK, though its economy is comparable with some English regions such as the North East. There are generally higher unemployment and lower economic activity rates, with the latter being more indicative so far as ill health and social exclusion are concerned.

Gross domestic product per head in Wales is well below the EU average, at some 82 per cent. It is about 83 per cent of the UK average. Furthermore, prosperity is spread very unevenly across Wales. In West Wales and the Valleys GDP is 72 per cent of the EU average, whilst in East Wales it is 97 per cent.³⁹

³⁸ *Stocktake of NHS Wales* (National Assembly for Wales, July 1999)

³⁹ Kevin Morgan and Adam Price: *The Other Wales: The Case for Objective 1 Funding Post 1999*, (IWA,

This economic background is reflected in a poorer health profile than elsewhere in the UK. Successive documents such as the Welsh Office consultative Green Paper *Better Health, Better Wales*, published in May 1998 and, more recently *A Better Wales*, published by the National Assembly in July 1999, have summarised Wales's main health problems in the following terms:

Life expectancy in Wales is three to four years shorter than the best in Europe. While infant mortality has declined, it remains higher than in most European countries. There are also clear inequalities in health within Wales. For example, the death rate from lung cancer in Blaenau Gwent in the eastern Valleys is about twice that in Powys in mid Wales.

A higher proportion of people in Wales report long term health problems (28 per cent) than England and Scotland (23 per cent) but fewer than in the North East of England (30 per cent). As elsewhere, unskilled manual workers are far more likely than professionals to experience such an illness; and in the Valleys nearly 18 per cent of the working age population is affected.

Wales has a higher proportion of people claiming sickness or invalidity benefit (11 per cent) than either England (6 per cent) or Scotland (9 per cent), but the same as the North East.

The death rate from heart disease in Wales is 19 per cent above the English rate, 10 per cent above the rate in the North East and 1 per cent above the rate in Scotland.

The cancer registration rate for men is 19 per cent higher in Wales than in England and the North East, and 7 per cent above the rate for Scotland; for women the rate in Wales is 16 per cent above the rate in the North East, 14 per cent above England as a whole, and 2 per cent above Scotland.

Overweight and obesity levels in Wales are increasing, with about half the population classified as overweight or obese.

Under age drinking in Wales, already high by European standards, is continuing to rise. In 1996, 40 per cent of girls and 50 per cent of boys had experimented with at least one illicit drug - double the level reported six years earlier.

In view of such statistics it is not surprising that Wales spends some 13 per cent more per head than England on the NHS:

Table 1 - NHS Spending per head in Wales and England⁴⁰

June 1998)

⁴⁰ *Stocktake of NHS Wales*

	Wales £	England £	Wales/England %
NHS spending: Comprehensive Spending Review plans for 1999-00	907	803	113

Per capita spending on private health care in Wales is less than half the level in England: taking this into account the total spend on health care is about 9 per cent above the English level. The high spending per head in Wales compared with England is also partially explained by Wales having a large number of relatively small hospitals, including a number of acute hospitals with overlapping catchment areas. There are 146 hospitals in Wales with 16,000 beds. However, only 16 hospitals have more than 300 beds. More than half have fewer than 50 beds. Of the 31 acute hospitals, 14 have fewer than 200 beds and only 3 have more than 600. These statistics go some way to explain why Wales has 22 per cent per head more hospital nursing and midwifery staff than England.

In part this reflects the rural character and sparse population across much of the Welsh landmass, together with the inaccessibility of many of the Valley communities. Nonetheless, it has sparked a debate with which the Assembly will have to grapple. There have been calls for a rationalisation of hospital provision and closure of some of the smaller community hospitals or the reduction in the number of their beds - calls which are inevitably, sometimes fiercely, resisted by the communities directly affected.

Wales has a high level of hospital admissions including relatively more accident and emergency admissions. Relatively more prescription items are dispensed in Wales with the drugs bill currently rising at double the level of inflation. In 1998-9 it was forecast to exceed the previous year by between 7 and 9 per cent. The April 1999 Welsh Office Departmental Report declared that steps being taken to limit the rate of growth included, "encouraging the use of pharmaceutical advice, generic prescribing, practice formularies, reviews of repeat prescribing, and monitoring of prescribing by health authorities."⁴¹

A particular Welsh issue is that there are relatively more people than in England on waiting lists for treatment and more facing longer waiting times. This is in spite of the fact that the country has more hospital beds per head, more admissions, and that the doctors and nurses are more productive. The raw statistics, shown in Table 2, reveal alarming increases that sparked debate early on in the life of the National Assembly's Health and Social Services Committee.

⁴¹ Welsh Office Departmental Report, April 1999

Table 2 - Changes in Waiting Lists and Times 1997 to 1999⁴²

	March 1997	March 1998	March 1999	July 1999
Inpatient and Daycase Waiting list	67,609	73,419	65,315	67,962
Waiting over 12 months	6,274	8,002	7,303	7,689
Waiting over 18 months	1,402	2,120	2,197	2,768
Out Patient Waiting list	101,308	112,758	134,364	151,908
Waiting over six months	5,956	10,340	21,828	25,615

Note:

(i) Inpatient and Day case waiting lists include patients awaiting inpatient or day case treatment, but excludes patients admitted as emergency cases, outpatients undergoing a planned programme of treatment, or expectant mothers booked for confinement.

(ii) Outpatient waiting lists comprises patients waiting for their first outpatient appointment.

Party Policies

In the first elections to the National Assembly in May 1999 health did not feature prominently in a debate that was generally low key across the board. The commitment of political parties in Wales to the health service is something taken for granted. In this policy area the assumption even extends to the Conservatives.

On the other hand, in the party manifestos health received the attention befitting a policy arena that attracts such a high proportion of spending within the Welsh block. In Labour's Manifesto *Working Hard for Wales* the party pledged to:

- invest an extra £1 billion in the NHS in Wales over the first three years of the Assembly's life;
- reduce waiting times for inpatient treatment to less than 18 months, and outpatient treatment to less than 6 months, by the end of the first term;
- reform the financial management of the NHS in Wales to ensure that the new funding is used to improve services, not finance deficits;
- ensure that health improvement programmes are in place in each Welsh health authority by the end of 1999;
- reform the financial management of the NHS to ensure that new funding is used to

⁴² *Waiting Lists and Emergency Admissions Paper*, presented to the National Assembly's Health and Social Services Committee, 22 September 1999.

- improve services not finance deficits;
- promote new opportunities for healthcare professionals to locate in areas where shortages have been identified;
- introduce NHS Direct, a 24-hour nurse-led helpline, to cover all parts of Wales;
- appoint a health supremo to break down the barriers between the NHS and local authority social services to eliminate wasteful 'bed blocking' where hospital beds are taken by patients whose long term care needs would be better served in the community.

These undertakings all deal with improvements and modifications to the inherited structure. In contrast Plaid Cymru's Manifesto *Working for the New Wales* sought fundamental change to the structure itself, aimed at completely removing the internal market. This would result in abolition of the Trust structure and a reorganisation of the NHS around units of clinical delivery. Plaid Cymru's system would then comprise:

- A Health Committee and ministry in the National Assembly, responsible for strategic planning and policy decisions.
- The five Health Authorities to be reconstituted democratically and to be responsible for commissioning and delivering all health priorities in their areas. The purchaser/provider split would be abolished. The HAs would employ and deploy the family practitioner and primary care services.
- The local Health Councils; these democratically constituted bodies would be the principal advisory mechanism to inform the Health Authorities of the specific needs of their area. They should evolve in a staged way, initially as Local Health Teams and eventually becoming Local health Councils.

According to Plaid Cymru, under these arrangements the Health Authorities would be responsible for the district and general hospitals serving their areas, but without rigid boundaries as the compartmentalisation created by the trusts will have gone. They would draw up health improvement programmes based on the health needs of their areas. They would collaborate on nationally - or regionally - provided specialist services. Their annual reports would be required to report on collaboration within the NHS and with other agencies including local authorities and the voluntary sector.

The Welsh Liberal Democrats' Manifesto *Guarantee Delivery* more closely followed Labour's in making specific commitments to ensuring the existing structures worked better. Indeed, the Liberal Democrats specifically pledged "to avoid further organisational changes in the NHS in Wales in the lifetime of the first National Assembly." Instead, it proposed a "new NHS Contract for Wales" which, amongst other provisions, would:

- introduce maximum waiting time of six months for patients to see a consultant after referral by a GP, to be achieved by the end of the Assembly's first term;

- introduce a maximum waiting time of six months for patients to receive treatment after seeing a consultant, again to be achieved by the end of the Assembly's first term;
- audit the links between poor health and economic deprivation to achieve better distribution of resources;
- abolish charges for eye and dental check-ups;
- appoint salaried GPs in areas where recruitment of family doctors is difficult;
- give the greatest possible autonomy for Local Health Groups within Health Authorities so that GPs can make clinical decisions without interference;
- establish an independent Welsh Health Policy Forum to advise the Assembly on health matters.

The Conservative Manifesto *Fair Play for All* was the least specific of all the parties on health policy. It undertook to defend the Conservative policies for GP Fundholding and accused Labour parties of "fiddling the statistics" to create an impression that waiting lists were falling. "We believe that local people are best placed to decide local priorities," it declared. "We are determined to retain and strengthen the existing health authorities. Health priorities should be determined locally and not by remote politicians."

What has become clear in the first few months of the Assembly's existence is that the weight of day-to-day administration continually threatens to obscure long-term targets and visions for change. All the politicians in the Assembly have the same complaint, the sheer volume of information crowding their computer screens. As one put it, "In Westminster there are more than 600 MPs tracking the administration. We only have sixty." More than any field this applies to the health service.

Strategic Policies Affecting the Health Authorities and Trusts

There are five health authorities in Wales. Established in April 1996, they replaced eight district health authorities and eight Family Health Services Authorities. The reorganisation was programmed to yield eventual savings of some £8 million a year by March 1999.

In the years leading to the establishment of the National Assembly appointments to the Health Authorities and Trusts drew their share of criticism from those concerned about the development of a Quango State in Wales. An outstanding example was the Conservative MP Ian Grist who lost his Cardiff North seat to Labour at the 1992 general election and soon afterwards was appointed chairman of the South Glamorgan Health Authority. When Labour came to power at the 1997 election the Welsh Office announced a policy of at least advertising such appointments. In future appointments will be scrutinised by the Assembly's Health and Social Services Committee.

The role of the Health Authorities includes analysing the need for health care in their areas, and commissioning accordingly. They are charged with supporting the contractor professions, protecting public health, ensuring firm stewardship of resources, and keeping in touch with, and responding to, the views of people and organisations in their areas. It will be the job of the National Assembly to produce enhanced and more transparent assessments of how effective the Authorities are in these tasks and, in particular, the last. The NHS is held in great affection by the people of Wales. But the engagement of the health service administration with the views and wishes of the public has hitherto lacked effective democratic accountability.

The Health Authorities are also responsible for establishing Local Health Groups to involve primary care provisioners and representatives of local government and community groups to work together to determine local services. The Welsh White Paper *Putting Patients First* (January 1998) set out objectives for retaining the distinction between commissioners and providers of health care, encouraging the NHS and social services departments to work more closely together, and generally fostering primary care. This was an ambitious agenda, quite different from the one being set in England. In particular the objectives were to improve health by:

- Developing local responsiveness through the establishment of Local Health Groups which will bring together GP practices, other health care professionals, representatives of social services departments and voluntary organisations. They will work with the local Health Authorities and Trusts in developing the services to meet local needs and priorities.
- Reducing health variations across Wales and tackling inequalities in health and access to health care.
- Continuing to develop evidence-based services through focused research and development.
- Ensuring that the NHS is health gain focused, seeking to reduce the number of premature deaths in Wales and improve the quality of life.

A major programme of mergers between NHS Trusts took place across Wales in April 1999, with their number being reduced from 25 to 16. A year earlier the Ambulance Trusts had been reduced from five to just one for the whole Wales. These changes aimed at promoting collaboration in place of competition and, eventually, saving money by releasing an estimated £7 million a year from administrative costs into patient care. The objective was for the reconfigured Trusts to operate according to three principles:

1. neighbouring Trusts should collaborate to improve the planning of admissions, reduce waiting lists, and develop more specialised services locally;

2. acute and community services should be combined to provide patients with seamless care from admission to hospital until recovery;
3. the Trusts now share boundaries with the unitary authorities enabling greater co-ordination between social services and the new Local Health Groups.

A new strategic framework for the development of medium to long-term health strategy in Wales was launched by the Welsh Office in October 1998 following publication of its consultation document *Better Health, Better Wales* the previous May. The key aim was to set a strategy for national, regional and local action to be taken forward by the National Assembly. Among its key proposals were:

- establishment of a multi-disciplinary Wales Centre for Health;
- development of Health Alliances in local authority areas;
- development of a Communicable Diseases Strategy for Wales;
- development of a Sexual Health Strategy;
- broadening the evidence base about health-related outcomes, through a Sustainable Health Action Research Programme.

As the National Assembly took over the reins, on 1 July 1999, a new Corporate Plan for NHS Wales was beginning to take shape. The Plan is due to be published on 1 June 2000. It will be incorporated into a Strategic Plan for the Assembly as a whole, to be published in the Spring of 2000. According to the National Assembly consultation paper on values, service priorities and spending plans, the Strategic Plan:

will include an unambiguous statement of our policy objectives, identify a manageable number of priority areas for action, set clear targets and inform the final allocation of our budget for 2000-01 and later years.⁴³

So far as Welsh health expenditure and priorities were concerned, however, these were already pretty much set, leaving a question mark over the extent to which the Assembly's new Health and Social Services Committee would wish or be able to alter them.

⁴³ *A Better Wales: A consultation paper on values, service priorities and spending plans* (National Assembly for Wales, July 1999)

Budgets and Targets

The current cash plans for the National Assembly's budget as a whole, according to the 1999 three-year Comprehensive Spending Review are shown in Table 3.

Table 3 - Welsh Spending Plans 1999-2002 £ million⁴⁴

	1999-00 plans	2000-01 plans	2001-02 plans
Total	7,456	7,908	8,334

Within this total the projected health and social services budget is shown in Table 4 (Annexe 6). A superficial examination of the figures reveals clear policy implications. The substantial increase in the social inclusion fund at the end of the period, for example, suggests that this may be used to assist with matched funding to draw down EU Objective 1 structural funds for the Valleys and other areas in West Wales where social exclusion problems are salient. As the consultation document *A Better Wales* comments:

Some budgets can help towards two or more objectives if used wisely and against a background of co-operation. Some additional funds - particularly the Social Inclusion Fund - are intended to help broker co-operation and initiatives rather than being added to the traditional budget silos.

Equally the steep rise in the 'Children' allocation after the first year points to forthcoming initiatives in this area. One example is the Children First initiative designed to raise standards of children in local authority care. Another is the responses that will be necessary to take account of recommendations likely to emerge from the North Wales Child Abuse inquiry.

Pressure Points

Amid the wide-ranging agenda and general complexity of issues that characterise the administration of health and social services in Wales three underlying themes have emerged that will be ongoing preoccupations for the National Assembly's Health Executive and Committee. These can be considered under the following headings:

- (i) **Pressures on the budget** - underscored and made more difficult by the cumulative deficits of recent years.
- (ii) **Pressures of modernisation** - the advance of clinical specialisation and high-tech

⁴⁴ *A Better Wales*

facilities, together with recruitment, and financial pressures, point to the need for investment in fewer acute hospital units than Wales currently has.

(iii) **Primary care** - responding to a debate about how resources and priorities can be shifted to this area of service delivery so that pressure can be taken off the hospital-based delivery of secondary care.

(i) *The Budget*

As noted at the outset, by the end of the financial year 1998-99 the Health Authorities and Trusts in Wales had built up cumulative deficits of some £72 million. The distribution of these debts between the five health authorities is shown in Table 6.

Table 6: Deficits accumulated by the Welsh Health Authorities (£ million)⁴⁵

	Gwent	Bro Taf	Iechyd Morgannwg	Dyfed Powys	North Wales	Wales
1998-9	0	4.1	2.5	10.6	1	18.2
Cumulative	9	24.5	7.7	24.3	7	72.5
Recurring	0	6.5	2.5	15.1	1	25.1

Table 6 shows that while in the past deficits have been incurred in all Health Authority areas, the current deficits are mainly concentrated in Dyfed Powys and Bro Taf. Bro Taf has the teaching and research responsibilities of the University of Wales College of Medicine, coupled with centrally directed changes in the funding of specialist services. The size of the Dyfed Powys area presents particular problems related to the sustainability of its network of small acute and community hospitals.

Stocktake of NHS Wales draws attention to these difficulties as well as listing more general factors which may have contributed. These include the overall resources of NHS Wales; resources at Health Authority and Trust levels; the impact of the internal market; failures to deliver cost savings; short termism; failures of accountability; and the role of the Welsh Office itself. It then goes on to advocate that the advent of the National Assembly provides an opportunity for making a new start and lists a number of recommendations, including:

- restoring financial discipline and giving value for money a higher priority;

⁴⁵ *Stocktake of NHS Wales*

- greater collaboration and partnership within and beyond the NHS;
- a longer-term, whole system approach;
- stronger strategic leadership and support for necessary change;
- greater realism, clarity and transparency;
- real engagement with the public.

(ii) Modernization

A major driver of change in the NHS generally is clinical pressure combined with a growing shortage of highly trained medical and nursing staff. Issues include:

- to attract staff hospitals need to meet higher standards in terms of consultant cover and the training and expertise of clinical staff;
- surgeons are becoming more specialised;
- research coupled with the provision of more sophisticated drugs and equipment mean a wider range of problems and complex conditions are able to be dealt with more successfully;
- the declining role of the generalist hospital doctor;
- increasing specialisation means that doctors need to serve larger populations to effectively apply their skills.

The Royal College of Surgeons calculate that a population of half-a-million is the minimum needed to ensure sufficient available expertise. To adopt this recommendation in Wales would require a drastic reduction in district general hospitals, from 16 to 6. On the other hand, the Royal College of Surgeons estimate was aimed mainly at large urban centres in England. The position in much of rural and mountainous Wales is quite different.

There is a tension between the demand for local provision of comprehensive care services and the pressure for specialised centres for complex care. Whereas convenience is served by the former, the evidence is that the latter is likely to provide improved specialist care for rare conditions or difficult interventions. Cancer care is a good example where treatment at a Cancer Centre is better than at a local cottage hospital.

This need not imply closures. Rather there could simply be a change of roles. For example the smaller hospitals could have a new role under the 'keeping Care Local' initiative employing telemedicine technologies currently being explored by the Welsh Institute for Rural Health (at Gregynog, near Newtown), Dyfed Powys Health Authority and the Welsh Office (now the National Assembly).

There is no doubt that the Health and Social Services Committee of the Assembly will soon

be grappling with these questions. For instance, former Welsh Office Health Minister, Jon Owen Jones, has argued that whilst sparsely populated areas in north and mid Wales should be treated as a special case, more focused centres of excellence should be developed in industrial south Wales.⁴⁶ Swansea, Cardiff and Newport are within half-an-hour's travelling time of half the Welsh population and could be developed into emergency centres for most of south Wales. At the same time he says the upper Valley towns have high health needs and are remote and so should warrant one large district general hospital. This should be located in Merthyr which has good access to the Heads of the Valleys Road and the A470.

Other district general hospitals should be dedicated to elective treatment with pooled clinical staff with the nearest emergency centre. In north Wales Glan Clwyd is well-located, halfway along the A55. However, Wrexham and Ysbyty Gwynedd would also need to provide emergency treatment.

Similarly, for west Wales Carmarthen, he argues, is the best location, but Ceredigion and south Pembrokeshire are too remote, and so Withybush (Haverfordwest) and Bronglais (Aberystwyth) should operate as satellites of Carmarthen.

In putting forward these proposals Owen Jones acknowledged that politicians instinctively campaign to protect local provision. For example, he himself campaigned for a decade (in the end unsuccessfully) to prevent the closure of the Royal Infirmary in his Cardiff Central constituency. But he added:

Llanelli's new Assembly member Helen Mary Jones has pledged that any reduction of services at Prince Philip will be over her dead body and Kirsty Williams who is chair of the Health Committee (and as such should have a wider view) has made similar comments about community hospitals in Powys.

What local politicians have to understand is that these decisions really are about dead bodies or bodies needlessly suffering prolonged pain. Parochial decisions on preserving the generality of treatment in *my* local hospital can be, and are, gained at the expense of service provision of patients across all of Wales.⁴⁷

(iii) Primary care

Stocktake of NHS Wales pointed out that the number of patients being treated by GPs is rising rapidly. It quoted figures that in the period 1982 to 1998 the number of patients seen per week in a north Wales surgery rose from 2,900 to 5,650, an increase of 95 per cent. The Policy Unit also pointed out that GP's decisions have the greatest influence on the way resources generally in the NHS are used. The advent of Local Health Groups meant that it

⁴⁶ 'Straight Choice for a Healthy NHS' (*Western Mail*, 1 September 1999)

⁴⁷ *ibid.*

would be possible for the needs of communities to be addressed in a more integrated way across the provision of medical and social care.

In her July monthly report to the Assembly's Health and Social Services Committee, Health Secretary Jane Hutt announced she would be tabling proposals to develop a new primary care strategy for Wales. Later in the year she would bring forward a paper for discussion by the Committee on the wider development of a primary care led health service.

In Wales the lead on the primary care debate has been taken by Dr Julian Tudor Hart, for many years a GP in Glyncoed (in the Valleys near Port Talbot) and now with the Welsh Institute of Health and Social Care at the University of Glamorgan. He has drawn attention to a crisis of provision of GPs in the Valleys, calling for a salaried structure for a new generation of doctors in the region. He has also argued that a much wider range of health workers is needed in primary care, working more imaginatively, with opportunities for using their data bases as a resource for research and economic development.⁴⁸

Administrative Governance

The pressures on the health service discussed above were among those that led the Welsh Office, in early 1998, to commission a study on the central administration of NHS Wales. Sir Graham Hart, previously Head of the Scottish Home and Health Department and a former Permanent Secretary at the Department of Health in Whitehall, was asked undertake a fundamental review with devolution very much in mind.

Since the abolition of the Welsh Hospital Board in 1974 the Welsh health service has been administered at the all-Wales level directly by Welsh Office civil servants, most of whom lacked hands-on experience of managing hospital provision. This is in contrast with the position in the English Regions where a tier of administration by health professionals was sustained. Arguably this contributed to some of the administrative failings with which the present-day health service in Wales is having to come to terms.

Certainly, the changes advocated by Sir Graham Hart pointed in the direction of giving health professionals a larger role in the management of the NHS in Wales. When it appeared as an internal management document in June 1998 his report, *The Health Responsibilities of the National Assembly for Wales*⁴⁹ was trenchant, containing an incisive analysis of the recent history of Welsh health service administration, together with a series

⁴⁸ *Going for Gold: A New Approach to Primary Medical Care in the South Wales Valleys* (Welsh Institute of Health and Social Care: University of Glamorgan, 1999)

⁴⁹ The report has never been formally published though it has been widely available to health professionals across Wales.

of forward looking and often radical suggestions for change.

Sir Graham began by noting that under the previous Conservative administration, led by John Redwood, the Welsh Office had adopted a hands off approach and generally a low profile in relation to NHS administration, leaving the initiative to the NHS Trusts on the ground. The Welsh Health Planning Forum, established in 1988, was abolished in 1995. *Stocktake of NHS Wales* noted that staff numbers in the health division were reduced from 200 in 1994 to 145 in 1999, in parallel with the drive to a hands off approach. It suggested that this contributed to the build of deficits in the funding of the service. The end result was lack of leadership at the all-Wales level and an absence of a strategic approach. Sir Graham said he had: “been very forcibly struck by the evidence I have received, from outside the Welsh Office as well as from inside it, that the NHS in Wales now requires a greater leadership from the centre (para. 10).” A few paragraphs on, however, Sir Graham added that the Welsh Office's capacity to lead was inhibited by inadequate staffing levels and inappropriate organisation. Yet as we have seen in the White Paper, *Putting Patients First*, the Welsh Office had set an ambitious agenda, quite different from the one being followed in England.

Sir Graham argued that a fundamental shake-up in the central administration of the health service was needed to respond to these various challenges. In particular it should be divided into two groupings to reflect the twin aims of protecting and improving the health of the public and giving strong leadership to NHS Wales. These aims should be clearly differentiated by creating:

- an NHS Directorate;
- a Health Protection and Improvement Group.

The head of the NHS Directorate (the NHS Director) should be the Accounting Officer for the NHS Vote and should report directly to the Permanent Secretary, as the Head of the Welsh Office Health Department does now. However, Sir Graham recommended that the NHS Director should not be responsible for the Health Protection and Improvement Group. To combine the positions would entail an unreasonable loading of the position. But, more importantly, the health protection and improvement agenda was equal to or more important than the NHS agenda itself and should be pursued in different ways. It should, Sir Graham said:

“operate predominantly through making connections with a wide range of services and activities inside and outside the Assembly - schools, social services, employers, food producers and so on - at national as well as local level. It should be responsible for leading the Assembly's corporate policy on health. It therefore needs to be closely meshed into the other work of the Assembly on social and economic issues, and not organisationally identified with a narrower NHS

agenda." (para. 30)

Sir Graham went on to advise that the restructuring he recommended would require the Welsh Office to be strengthened in at least four ways:

1. there would need to be an increase in the number of staff handling health issues;
2. presently all the top staff in the Welsh Office Health Department are career civil servants - the NHS Directorate would need a greater input of senior people with personal experience of the NHS;
3. better use needed to be made of all available sources of professional advice and action;
4. there was a need to change Welsh Office culture and working methods to meet the demands both the Assembly and its electorate would place upon it.

This last was perhaps the most far reaching of Sir Graham's recommendations. For as he said:

"I believe devolution will lead the public and politicians to have rather higher expectations of its civil service; in particular, they will expect the Office to be more active in developing new policies for Wales and putting those policies into effect on the ground. And they will expect those policies and actions to reflect Welsh needs and to be cohesive, involving the pursuit of broad, cross-cutting objectives and programmes. This will be challenging because Government (central **and** local) has found it notoriously difficult to pursue policies that span the major interests of more than one department." (para. 31)

Later in his report (para. 76) Sir Graham returned to this need for a culture shift in the Welsh office's operation and management style, with the following practical suggestions:

(i) Top management should select a relatively small number of priority issues on which its attention should be primarily focused: "In my experience most senior civil servants pride themselves on being fully informed about everything that is going on in their Department, but this can prevent one from devoting enough time to the big issues."

(ii) The handling of most issues should be delegated and emphasis should be put on enabling staff to achieve and rewarding them when they do.

(iii) The team's top priority issues should be those which particularly need their input, because they are of strategic importance and, usually, because they cut across the organisational structure of the office. Examples include the health agenda set out in the Welsh Office May 1998 Green Paper *Better Health, Better Wales*; the May 1998 White Paper *Pathway to Prosperity: A New Economic Agenda for Wales*; the European agenda; and Sustainable Development.

(iv) Although the Permanent Secretary's senior deputies are likely to continue to have a main policy brief, for example Economic Policy or Social Policy, it is

important for each of them to take responsibility at their level for leading on cross-cutting issues which involve staff in the other's sphere.

(v) The Permanent Secretary should establish a small Policy Unit to support the top team in developing policy across boundaries.

(vi) The Office will need to develop greater team-working, action-oriented, including people from outside, dedicated to cracking specific problems on tight time schedules.

(vii) Closely allied to the previous recommendation there should be a greater emphasis put on developing skills of project management amongst the higher echelons of the office.

The large majority of Sir Graham's recommendations were accepted and were already being implemented, ahead of the establishment of the National Assembly. So, for example, from April 1999 an NHS Directorate with responsibility for the strategic management of the NHS in Wales was in place⁵⁰.

Accountability

The most effective forum for democratic accountability within the National Assembly for decisions and policies affecting health and social services will inevitably be the designated Subject Committee. The fact that the Labour administration is operating as a minority government, with therefore a majority for the opposition parties on the Subject Committees, is calculated to provide them with a further enhanced role.

The Health and Social Services Committee is chaired by Kirsty Williams, the Liberal Democrat AM for Brecon and Radnor. The Committee has four Labour members including the Assembly Minister for Health and Social Services Jane Hutt, three Plaid Cymru members, and one Conservative AM. The Committee meets on a fortnightly cycle, hearing a monthly report from the Health and Social Services Minister. The September 1999 report included:

- the need for the Assembly to approve a Statutory Instrument bringing to an end GP Fundholding in Wales emanating from the 1999 Health Act;
- proposals dealing with an amendment to the Food Standards Bill currently passing through Parliament to establish an Advisory Committee for Wales;
- progress with the programme emanating from the Green Paper *Better Health: Better*

50 On 18 March 1999 the Welsh Office advertised three key appointments to the new NHS Directorate: Director of Operations (Deputy NHS Director), Director - Health Services Policy, and Director of NHS Human Resources.

Wales; a report on the Meningitis C Vaccine Programme;

- a report on waiting lists;
- a briefing on the implications for wider health benefits of the introduction from 5 October of Working Families Tax Credit and Disabled Persons Tax Credit.

Intervention of the Committee has so far been most clearly seen in its response to *Stocktake of NHS Wales*. The minutes of the Committee's meeting held on 21 July record these as follows:

- The Committee welcomed the NHS *Stocktake*, but some members had expected more factual information and figures broken down at health authority level. The remit of the report was limited to an analysis of the financial management of NHS Wales and it did not include any clinical reviews. A more comprehensive picture will be available when the Corporate Strategy is released in the Autumn.
- Higher spending on health in Wales is a consequence of poorer health levels. Therefore the current deficit could be as much as a result of under-funding as financial mismanagement. Average Trust management costs are lower than England. A full debate on what the health service can actually deliver is required, with consideration of demand, rationing and costs.
- Under the internal market spending was not effectively monitored and managed. No attempt has been made by the *Stocktake* to cost that failure, or the savings that might be achieved by its demise. The move away from internal competition should see a move to more openness and transparency, with information from Trusts more freely available.
- Wales has led the way in reducing the level of overheads and has attempted to decrease management costs by £12-13 million since Health Authority reconfiguration in 1996.
- There was concern that the convergence in the Barnett Formula will mean a relative reduction in money and consequently services for Wales where there is greater need.⁵¹
- Trusts that have not gone into debt should not have to subsidise those that have. The increased financial settlements this year and agreed recovery plans should prevent this. However, this settlement has greatly reduced the central reserve. The allocation

⁵¹ The Barnett formula, which allocates increases in UK public expenditure on the population basis of England (85%), Scotland (10%) and Wales (5%), exerts a downward pressure on the growth available to the NHS in Wales. As *Stocktake of NHS Wales* puts it:

This effect arises because, although the baseline health provision in Wales represents a higher (13%) spend per head of population than that in England, increases made as a result of the Comprehensive Spending Review process are calculated on the basis of the Barnett formula. Unless additional resources are made available to compensate for the shortfall, this means that the year-on-year growth in the provision for the NHS in Wales is lower than that in England.

formula must be looked at before 2001, with greater consideration of variables such as rurality and sparsity.⁵²

- The Committee welcomed the Assembly Secretary's assurance that there is no secret agenda for hospital closures or staff redundancies to reduce costs. There would be difficult decisions ahead, but there would be greater consultation in making them.

When it next met, in September 1999, the Committee immediately responded to the 'difficult decisions ahead' by demanding greater resources for NHS Wales. At the start of the meeting it passed a Plaid Cymru motion, with Health Minister Jane Hutt abstaining, calling for extra funds directly from the British Treasury - that is to say, without intruding on the rest of the Welsh block allocation. This was partly in response to the report on hospital waiting lists tabled for the meeting, referred to earlier.

The following week, at Plaid Cymru's annual conference in Llandudno, the party adopted a policy of restricting the number of drugs which family doctors can prescribe. Plaid Cymru's health spokesman, Dr Dai Lloyd AM, said the drugs bill was taking up 11 per cent, and rising, of the NHS Wales budget. Reducing the size of the drugs list would reduce costs. In a response to the Plaid Cymru motion demanding extra funds for NHS Wales, Assembly First Minister Alun Michael fired off a letter to the *Western Mail*, which revealed some of the frustration caused by expenditure constraints:

As Plaid Cymru is pressing for increased spending not only in health but in a whole range of other areas such as education and training, economic development and agriculture, it must now explain which services it would like to cut to finance its endless shopping list within a cash-limited budget. I make no apology for insisting that NHS trusts and authorities live within their means and

⁵² The present Welsh formula for distributing funds between the Health Authorities was reviewed by a joint Welsh Office/Health Authority Resource Allocation Working Group in 1998. This considered two key issues:

Needs - The formula is based largely on needs represented by mortality rates and age structure. The working group decided that this was less effective in capturing needs than the English formula which takes greater account of social deprivation.

Costs - The review concluded that the formula should continue to take account of the extra cost of providing community and ambulance services in sparsely populated rural areas, but should make no adjustment for the costs of providing acute services in those areas, on the grounds that no evidence could be found to support this.

Ministers at the time decided not to change the formula at that stage for two main reasons: (i) it would have benefited Bro Taf, Iechyd Morgannwg, and Gwent at the expense of Dyfed Powys and North Wales; and (ii) the formula was being reviewed in England. *Stocktake of NHS Wales* recommended that change should not be undertaken immediately in order to preserve stability, but that the 2001 census would provide an opportunity to take a fresh look at the formula.

end the practice of accumulating debts.⁵³

Within less than three months of the National Assembly assuming its powers, the political battle lines were being drawn. Behind the rhetoric over funding, however, were important issues of clinical governance. They were given fresh transparency and urgency by the enhanced level of information forced into the open by the democratic processes of the National Assembly.

Setting the Budget

The new openness was tested during the Autumn by the Assembly's budgetary process (see box on next page). This followed a procedure that had long been familiar within the previous Welsh Office dispensation, but hidden from view. Now it was conducted fully in the open. By the end of November and after intensive negotiations between the parties the outline budget making allocations to the Assembly's main spending areas, shadowed by the Subject Committees, was agreed. Plaid Cymru abstained in the crucial vote and allowed the budget through. In return the government agreed that, subject to consultations with clinicians and legal opinion on the Assembly's competence, free eye tests would be introduced in Wales from October 2000.

Table 7 in Annexe 6 gives the budget as debated and approved by the Assembly at the end of November, with a breakdown for the main subject headings. The tables are for the financial years 2000-2001 and 2001-2002 with the changes proposed compared with the original Welsh Office baselines.

In considering the Preliminary Draft Budget of 4 November, each Subject Committee was advised that no additional funding would be made available to the group of programmes (or Main Expenditure Group) within its ambit. There was only the possibility of switching resources between budget lines (that is, within the Main Expenditure Groups).

⁵³ *Western Mail*, 25 September 1999

Budget Planning Round - Timetable

- Paper issued by Finance Secretary Edwina Hart on 23 June outlining inherited Welsh Office expenditure baselines, and inviting the Subject Committees to present their budget priorities to Assembly Secretaries. Assembly Secretaries to respond to Edwina Hart with priorities by 27 September.
- Public consultation document issued on 12 July - *A Better Wales*. Consultation closed 3 September. The responses were considered by the Subject Committees.
- Bilateral discussions between Finance Secretary and Assembly Secretaries during October.
- Preliminary Draft Budget discussed in Cabinet during first week of November.
- The Preliminary Draft Budget was published on 4 November and was debated in the Plenary session on 10 November.
- Subject Committees discuss their particular budget allocations and asked to present their views to the Finance Secretary by 24 November.
- Draft Budget paper published on 26 November.
- Motion to adopt Draft Budget tabled in the Plenary session on 1 December.
- Assembly Secretaries consult with Subject Committees on detailed budget allocations during December.
- Detailed budget to be finalised, and motion to ratify it, by early February.

There were slight changes in the Draft Budget figures published on 26 November compared with those in the Preliminary Draft Budget of 4 November, in response to the Subject Committees' requests for further allocations in key priority areas. Some of the changes, however, were made possible as a result of the Chancellor's Pre-Budget Report of 9 November and other allocations from the Treasury, which have increased the Assembly's budget by £1.966m in 2000-01 and £0.792m in 2001-02. The total budget for Health and Social services has been increased by £12.1m in 2000-01 and £10.1m in 2001-02, compared with the inherited Welsh Office plans.

In the Draft Budget, direct funding to Health Authorities and NHS Trusts was cut by £17.5m for 2000-01 and £18.5m in 2001-02. The bulk of this cut in funding has been transferred to the Family Health Services (FHS) budget line. The Finance Secretary indicated that these transfers are a "technical point". The transfers relate to non-discretionary expenditure which meets the remuneration costs of the NHS contractor professions (GPs, dentists,

opticians). It is reserve funding which had previously been included in funding for Health Authorities and Trusts. The proposals in the Draft Budget are to increase FHS provision by £24.5m in 2000-01 and £25.1m in 2001-02, compared with the original Welsh Office baselines. Technical transfers aside, funding for Health Authorities and Trusts has actually increased by a total of £14m over the two years, compared with the original baseline, which includes £6m transferred each year from the Capital Modernisation Fund.

Provision of £3m is proposed for the new National Strategy for Carers from 2000-01 onwards and new provision of £0.5m for the proposed Commission for Care Standards. An extra £0.5m has been allocated for 2000-01 onwards to children's services and £0.1m to the new Children's Commissioner.

Ahead of the Preliminary Draft Budget, the Health and Social Services Committee had asked for free eye tests and dental checks to be extended, but this was turned down owing to an estimated additional cost of £15m per year. However, when presenting the Draft Budget on December 1st, the Finance Secretary announced that an additional £7.9m had been made available from the Treasury for 1999-00. An allocation within this addition is being set aside for the possible extension of free eye tests from October 2000, following consultation with clinicians and after considering the Assembly's powers in this area. The extra money is also aimed at increasing capital investment and enhancing mental health services. As the Finance Secretary, Edwina Hart, put it in the budget debate on 1 December:

"I am pleased to announce an additional allocation from the Treasury for this year of £7.9 million. I propose to use this money to respond to the Health and Social Services Committee's priorities, following consultation with the Assembly Secretary for Health and Social Services. In understand the support for free eye tests, which several Assembly members have put forward as a priority."⁵⁴

On the face of it this sounded as though the Assembly Executive were responding to policy suggestions from the Subject Committee in the 'inclusive' way that had established itself as part of the rhetoric of the government when talking about the way they wished to see the Assembly working. More probably, however, was that it reflected an older fashion of politics. As a Conservative member, David Melding, ventured to ask the Finance Secretary:

I wonder if you have calculated - how much was your payoff to Plaid Cymru to get your budget through ? [*Assembly Members 'Oh'.*] Do you have a figure in mind?⁵⁵

Whether this policy initiative resulted from 'inclusive' discussion in committee or whether it was the result of inter-party dealing to get the budget through in one sense is irrelevant.

⁵⁴ National Assembly for Wales, Official Record, Wednesday 1 December 1999

⁵⁵ National Assembly for Wales, *ibid.*

What matters is that there was a significant health policy intervention and this came as a result of the Assembly processes making a difference to what otherwise would probably have been the case under the old Welsh Office regime.

England

Introduction

The *Devolution and Health* report commented that the English health service made up around 85 per cent of the UK total, and thus had a momentum and direction that were unlikely to be perturbed by whatever the other 15 per cent did. There was unlikely to be significant pressure to reflect any Scottish or Welsh innovations in English practice. It also noted that the NHS in England did not appear have a *regional* agenda and the English approach involved a system of *national* policies and targets, with *local* initiatives to meet them. However, there were forces in play which would demand from the English NHS a regional, rather than local, response, and therefore a degree of strategic flexibility by the NHS at regional level might be required.

The drivers for such change, it was argued, were to be found in the Government's plans for regionalism in England, starting with Regional Development Agencies (RDAs); and in the public health agenda, which would require more partnership working by the NHS at regional and local level.

Although health was not proposed as one of the core functions of the RDAs, public health was one of the non-core areas in which they would have major consultative and advisory roles. The RDAs were likely to see the NHS bodies in their regions as essential partners in their activities, both for the contributions that they could bring to improving the health of regional workforces, but also as major regional employers in their own right.

It was anticipated therefore that the NHS was likely to come under increasing pressure from the RDAs to engage more fully in the regional development agenda. The report stated that changing the geographical structure of the NHS Executive's Regional Offices to match that proposed for the RDAs would help facilitate co-operation. Since the report was published there has been a reorganisation of NHS regional structure, the most significant aspect of which is the creation of a single London Region which matches the boundaries proposed for the Greater London Authority. Other changes to the English NHS regional boundaries have brought them closer to the boundaries of the Regional Development Agencies although some mismatch remains in the north of England. Full co-terminosity has not been achieved.

The report questioned the extent to which the English NHS could stand outside an increasingly dynamic regional level of policy development. The objectives of the English public health Green Paper were likely to be furthered if the NHS was an active participant in the development of regional regeneration and economic development strategies.

One possible benefit to be derived from devolution of responsibility for managing health

services - and indeed also for the health of local populations - is increased ability to work across the boundaries of services and organisations. The hypothesis here is a simple one: it is that the creation of shorter chains of command, greater geographical propinquity of service headquarters, 'general closeness to the customer', smaller and more tightly-knit policy communities, a greater sharing of values and purposes, should all make easier the joint planning and administration of services of all kinds.

However, our prejudice - it can hardly qualify as an academic hypothesis - is that in the English case, despite all the rhetoric about the principles of 'joined-up government', it will in practice prove as difficult as ever to integrate planning and delivery of different services which are ultimately accountable to different Ministers in London. In reviewing English developments in 1999 we sought to test the extent to which these views were supported by the beginnings of English Regional government. We also reviewed developments in London.

Links between economic development and health services in the English regions

Regions are an important unit of analysis partly because they are, in quantitative terms, more nearly comparable with the devolved countries and partly because they are the sub-national level to which, in some distant future, a degree of autonomy on the Scottish, Welsh or Northern Irish model might be devolved. But which kind of regions? We acknowledge that comparison is made the more difficult by the fact, discussed above, that there are at least two major groups of regions whose boundaries are not always identical - the regions of the NHS Executive and economic planning regions. This lack of co-terminosity is a first significant contrast with the position in the three non-English countries, and may of course be one of the factors hindering joint working in some regions.

We shall be monitoring the working relationships between the NHS and the economic planning regions, and specifically between the regional offices (ROs) of the NHSE and the RDAs (and, to a lesser extent, to the ancillary Regional Assemblies and Chambers). There are eight NHS ROs (including London), each part of an overall structure more or less tightly controlled by Department of Health Ministers in London. There are nine RDAs (including London), established by a 1998 Act with the tasks of promoting sustainable economic development and social and physical regeneration in their regions. They are directly accountable to the Secretary of State for the Environment, Transport and the Regions.

Some degree of local accountability is, in principle, provided by the parallel existence of Regional Chambers and Assemblies. Chambers have been part of government policy since the 1997 White Paper *Building partnerships for prosperity*. They are non-statutory bodies whose primary task is to oversee the work of the RDAs, who are required to take account of

their views (as well as to consult local authorities). 70 percent of their members are representatives of local authorities. They derive, though are sometimes separate, from previously existing voluntary regional 'assemblies'. RDAs became operational on 1 April 1999. Since then their most significant activity has been drafting, and consulting on, economic strategies for their regions.

During this first year of the project we have consulted NHS regions and RDAs, as well as informed observers, about the working relationships between the two sets of regional bodies. Our interest was in the extent to which RDAs were engaging with the health agenda, in the working relationships which they established with the different levels of the NHS, and in the involvement of NHS organisations in partnerships with RDAs and other regional stakeholders.

So far, inevitably, the responses that we can report are almost entirely in terms of preliminary administrative arrangements and a certain amount of cross-service consultation. Some of these may of course lead nowhere. Others may, alternatively, be the essential starting-point for effective later joint planning and working and ultimately for better outcomes in terms of improved health.

Our enquiries focused on the existence of any formal mechanisms for consultation between the RDAs and ROs or other NHS organisations; on the place of health issues on RDA meeting agendas; on references to health issues in draft regional strategies; on structures for policy formulation and implementation; on working relationships between ROs and RDAs; and on both parties' perceptions of key local health policy issues. (The position in London is covered in a separate section below.)

Mechanisms for consultation

Responses to our question about 'formal mechanisms for consultation' varied partly according to respondents' understanding of the term 'formal'. In one case the RO replied, "The RDA has not established any formal mechanisms in this region for consulting with the RO or any other NHS organisations." In another case, the more positive statement was made that, "Formal contacts with the RDA were made at its point of inception". However, this was amplified with the two examples that the RO had attended the formal launch of the regional strategy, and that the RDA chief executive had contributed to a conference for NHS chief executives. Not all observers would agree that these constitute 'formal mechanisms'. In general, the latter seem to have been lacking: an RDA simply said that it had been "consulting health organisations in the same way as we have been consulting other organisations"; another RO acknowledged that its working relationships with its RDA were relatively undeveloped, though the RO had contributed to the process of bidding for the Single Regeneration Budget and had commented on the draft regional economic strategy; an RDA noted that the RO had been represented on

the working parties “developing our strategy themes on social exclusion and sustainable developments”.

A striking contrast with the relatively informal arrangements outlined above is provided by developments in three other RDAs. In the East Midlands, the Trent RO has funded the two-year secondment of a public health specialist to the RDA, with the specific task of providing public health expertise so as to aid “joined up thinking and action regarding policy development and implementation and its impact on the health of the East Midlands”. This post evolved from the activities of a “wider government development team”, set up in 1998 and including representatives of the RO, the Government Office, the RDA, the Regional Assembly and 7 local health authorities. It is hoped that the team, originally seen as a forum for sharing agendas, will be a mechanism for implementing an integrated regional strategy. A similar post is to be created in the South Yorkshire and Humberside RDA, which covers the northern part of the Trent NHS region.

In the north west, the Assembly established a ‘Health Task Group’ in January 1998, to define the ‘health’ agenda for the new regional bodies. Its report, *Health: a regional development agenda*, was published in 1999. The executive summary of the report noted that: “Efforts to regenerate the North West - economically, environmentally and socially - will bring significant health benefits to the population.” The RDA took note of the report and established a Health Steering Group, chaired by the RDA member who has an explicit health brief. The Steering Group includes two NHS representatives. An NHS official has been seconded to the RDA to support these activities. The RO comments that these arrangements provided a focus for the formal consultation on the Regional Strategy. The latter was circulated to all NHS trusts and authorities in the region as well as to the RO.

In the north east the RO arranged a short-term secondment to the RDA. One aim of this was to develop a structure to enable the health sector to co-ordinate a response to the regional economic strategy; a formal response was in due course made by the NHS regional chairman to the chairman of the RDA.

Health Issues on RDA agendas

Most responses indicate that health issues have not normally featured on agendas for RDA meetings, although they have surfaced, to varying extents, in discussions of draft economic strategies. In the West Midlands, the NHS White Paper *Saving Lives* was an agenda item in a sub-group discussion, and was presented to RDA staff at a briefing meeting.

Health issues in regional economic strategies

Early versions of draft strategies in some cases included few - or, in one case, only one - references to health issues. This situation changed somewhat as a result of the consultation

process. Thus the North West plan recognised that a healthier population should be a specific by-product of the RDA's work in stimulating sustainable economic development and social and physical regeneration; and, reciprocally, the contribution that improvements in people's health makes to improved productivity. The North East, East of England and South West plans mentioned the contribution to economic regeneration made by health service organisations as employers. The North East plan also recorded a joint commitment, between the RDA and the NHS RO, to a *concordat* to develop working partnerships which would, "ensure that economic and social regeneration are sustained by health improvements across the region."

Structures for policy formulation and implementation

In most cases few formal structures or processes have yet been established. In the west midlands, the economic strategy was being developed through four 'cross-cutting framework plans' and four 'action plans', in some of which the NHS executive had been involved. Formal steering groups were to be established relating to these plans. In the north east preliminary plans for implementing the strategy included proposals for teams in which the NHS RO and others could be involved. The south east RO hoped to be involved in RDA groups addressing topics such as workforce and training/learning. In the north west there is the Health Steering Group, already mentioned. The regional strategy contained a commitment to develop a health strategy for the north west; this will be produced by a partnership involving the RDA, Assembly, Government Office and the NHS RO. In the east midlands, in addition to the NHS-funded post already mentioned, discussions have been held about a possible 'Regional Integrated Policy Agency'.

Evaluation of arrangements for joint working

In most cases some thought had been given to developing arrangements for evaluating the success or otherwise of attempts to work across organisational boundaries. No such arrangements were yet in place. One RDA commented, reasonably enough, that "joined up policy formation and implementation is as much an issue for central government as it is for regional development agencies."

Salient issues

We asked NHS ROs their view on the current key issues in health policy. Those mentioned included inequalities in health and social exclusion, transport and health, rural issues, workforce health, greater consumption of fruit and vegetables, more exercise, warmer housing and the formation of a regional health strategy addressing the social, economic and environmental determinants of health.

Conclusions

At this early stage it is hard to assess, from arrangements of the kind summarised above, either the degree of conviction that those involved actually bring to the task of inter-agency collaboration, or the future impact of such arrangements. Our other less formal discussions so far with NHS authorities reveal considerable interest on their part in integrating their activities with those of regional and local authorities - that is, with bodies responsible for sub-national economic development, land-use planning, transport and housing among other services. Some RDAs seem to share this interest and to appreciate the possible relevance of health authorities' activities to the economic agenda, and vice versa. But there are many obstacles to effective collaboration. These include, on the one side, lack of interest in the health agenda on the part of some RDAs, and differences of approach between RDAs and related Chambers and Assemblies and, on the other hand, the government's attempt to exercise tight central control over the NHS - to the extent of trying to run it, as one health manager told us, on "Marks and Spencer lines - selling identical products everywhere at identical prices". Without greater devolution of responsibility for decision-making from Richmond Terrace to NHS regions than currently permitted or, it seems, envisaged, the latter may find it hard to plan and work closely with non-health agencies so as to achieve the objectives of either party by achieving local solutions to local problems.

London

The Greater London Authority (GLA), to be elected in May 2000, will consist of a directly elected Mayor and an elected assembly of 14 constituency and 11 list members. The GLA will have no powers or responsibilities relating to London's health services. The principal purposes of the GLA, as expressed in the relevant legislation, are to promote economic development and wealth creation, social development and environmental improvement in greater London. In using its powers to further these purposes the GLA must have regard to the effects of its actions on the health of persons in greater London. It is not, however, required at any stage actually to consult the NHS.

A mayor, in particular, with a power base different from that of the Westminster government will be able to focus and to project opinions, of some political significance, on matters about which Londoners (like all other UK citizens) feel strongly. The interesting and important question, for this project, will be how far the mayor and assembly will use the political authority derived from their independently elected status to attempt to influence policies and practices in London's health services, despite their lack of formal legal powers relating to these services. A secondary question concerns the scope of the assembly's interests: are members likely to be preoccupied - as has been predicted of assembly members in the devolved administrations discussed elsewhere in this report - with discrete issues such as the closure of individual hospitals or, with only 14 constituency members nearly balanced by 11 list members, will the assembly be able to develop some thinking about the London region as a

whole?

The significance of the new London arrangements and their working in practice will not be confined to London. The GLA will be the first example, however limited its powers, of regional devolution in England. As such, it may provide lessons and/or a model, positive or negative, for other regions. In a consultative document on the implications of current constitutional changes the Royal College of General Practitioners has observed that, "London...may provide a working example for the College as to what it may expect from regional development and how it may respond." Experience in London is likely to give, for example, a foretaste of problems which may arise in other regions from a lack of 'constitutional fit', as between a locally-elected authority charged with economic and social development, and centrally appointed health authorities directly accountable only to the Secretary of State. There will not, however, be problems with NHS boundaries; the creation of a single London region can be seen as a major advance which will make joint activities more feasible. (There are 16 health authorities in the London region.) As noted in a recent paper prepared for the King's Fund, "Because the GLA is the first instance of English regional devolution, this is the bottom of a very steep learning curve."⁵⁶

The King's Fund has campaigned for the Mayor and Greater London Authority to play an active role in promoting the health of Londoners. Davis and Kendall argue that one reason for this is to tackle the democratic deficit in health policy: the Mayor and Assembly provide and opportunity to bring greater accountability and openness into this policy area.⁵⁷ In proposing this they distinguish between the Mayor taking an interest in *health* with the prospect of the Mayor taking an interest in London's *health services*. They do not argue for the Mayor to have any executive powers over health services in London, but claim:

it would be in the interests of the NHS London region for the Mayor to have a clearly defined role in promoting health across the capital and for the Mayor to be bound into a partnership arrangement for this purpose.⁵⁸

Much work has been done over the past year, by the new NHS regional office for London, to develop a 'health strategy for London'. From the start this exercise was explicitly based on the principle that "the issues that determine the health and well-being of people living in London are much broader than just health services". The strategy would thus aim to achieve a multi-agency, multi-disciplinary approach. During 1999 links were strengthened with other agencies, especially local authorities. The timetable envisaged six stages, of which the last would aim to "inform Mayor and GLA from 2000."⁵⁹ At the time of writing this report, the

⁵⁶ Davies, A. *Health in London: Power and Responsibilities of the GLA* (The King's Fund: November 1999)

⁵⁷ Davis, A. and Kendall, L. *Health and the London Mayor* (The King's Fund, 1999)

⁵⁸ *ibid.*

⁵⁹ 'A Health Strategy for London': www.doh.gov.uk/london/hstratl.htm

mayoral campaign had barely begun and there were few signs to indicate how any of the candidates would interpret their mandate, and use their powers, in the health field. The pledge of Frank Dobson, the Prime Minister's preference as the Labour Party's candidate for Mayor, to appoint a medical officer of health for London was one of the few specific exceptions to this.

The United Kingdom

Introduction

Devolution has brought to the United Kingdom a new set of activities, to which the term 'inter-governmental relations' has been applied. This involves the transactions between Whitehall and the devolved administrations. In the *Devolution and Health* report we commented that, "The Department of Health would need to distinguish more clearly between its all-UK role and its responsibility for the health service in England." This actually over-simplified what is a very complex situation. This complexity results from the asymmetric nature of devolution. As Annex 7 shows, the extent of devolution in health-related policy areas differs from country to country. In fact, Northern Ireland has received the greatest degree of devolution, to the extent that even regulation of professions is devolved. Scotland has the next greatest array of devolved powers, with Wales receiving the least. As a result, although post devolution the vast majority of the Department of Health's work (it has been estimated at 85 percent) is concerned with England alone, there are also occasions when the Department is working for England and Wales, yet others where it works on behalf of Great Britain, and others again where it represents the whole of the United Kingdom. The all-UK category includes dealings with the European Union, an area that many have predicted might bring difficulties. The *Devolution and Health* report commented:

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

The Professions

It is necessary to attempt to monitor developments in health policy at the all-UK level. Operating at the UK level are a number of organisations, not least the professions, which exert a powerful influence on the health agenda. The *Devolution and Health* report noted that these professional bodies were likely to seek to maintain conformity in standards of clinical practice, education and training, terms and conditions of service. This might act as a brake on those new developments which implied divergence between the four countries of the United Kingdom. We have sought particularly to monitor the response of the professional bodies to devolution.

In most cases these have traditionally acted as a force for common standards and practices throughout the UK. Devolution presents them with two major challenges in particular.

First, they have to decide in general whether the creation of three more nearly autonomous political and governmental systems makes it necessary for them to adapt their own organisational structures and ways of working. Secondly, they will have to decide on specific issues whether to work for uniform practices throughout the UK or whether to accept - or indeed to press for - appropriate country and regional variations to reflect different local conditions.

We asked the leading professional bodies and Royal Colleges what action they were taking, or envisaged taking, in response to the actual or anticipated effects of devolution. The specific questions which we put to them were as follows:

1. Have you introduced any changes to your own governance structures and processes in response to devolution, or are you planning to make any such changes in the near future?
2. What challenges do you consider that your profession faces in ensuring that it can influence health policy formation in a devolved system?
3. Do you anticipate any other problems for your organisation as a result of the changes brought about by devolution, in either the short or the long term?
4. To the extent that your profession is affected by decisions made in Brussels, do you envisage that devolution will bring any changes or problems in your working relationships with European Union institutions?

The replies which we received revealed wide divergences in both the extent to which organisations had already taken action of any kind, and in the action taken. Thus the Royal College of Paediatrics and Child Health declared that they had “certainly made many changes in our own structure in response to devolution”. The General Dental Council, in contrast, confirmed that they had “not introduced any changes to our current structures... nor do we have any immediate plans to make such changes.” The latter continued that they had so far given no detailed consideration to the issues covered by the other questions put to them. This contrasted with the situation of the Royal College of General Practitioners, which had not only already expanded its existing offices in Edinburgh and Cardiff, and recruited additional staff for both, but had set up a working party, as long ago as the end of 1998, “to consider the future organisational structure of the College in the light of the changes to the UK constitution”. The report of this working party, quoted below, was due to be considered by the College’s Council at the end of January.

Structures and processes

In many organisations the countries other than England were already specifically represented on their UK-level governing body. Thus the ophthalmologists’ Council includes two representatives from Scotland and one each from Wales and Northern Ireland. Similar

patterns are found in other bodies. In addition, some organisations already had some form of territorial representation at sub-UK level. Thus the anaesthetists, the GPs, the paediatricians, the radiologists, the British Medical Association, the Royal College of Nursing (RCN) all have well-established Scottish committees or councils; some of these also have similar bodies in Wales, usually more recently established, and in one or two cases also in Northern Ireland. For example, the RCN Scottish Board was established in 1916, its Northern Irish and Welsh Boards in 1948 and 1970 respectively. The paediatricians are unusual in having recently set up an 'all-Ireland' committee. The General Dental Council had only a London-based Council representing the whole of the UK. As an immediate response the RCN had already set up a weekly telephone conference between its several offices to ensure that they were all abreast of developments UK-wide, and consistent in their responses to these. It had also appointed additional staff to support the country Boards in work generated by devolution.

The mere existence of a regional structure does not, of course, necessarily indicate full devolution of responsibilities to the units in the countries concerned. At one extreme is the BMA, which for many years has had devolved Councils and supporting offices in Scotland, Wales and Northern Ireland. The BMA noted that local staff, "have virtually autonomous power to conduct negotiations with the relevant Government Departments". The general practitioners, by contrast, describe their Scottish and Welsh Councils, as having "some autonomy although this is not clearly defined". The ophthalmologists, both of whose 'regional affairs' committees are chaired by the College President, observed that these committees "serve mainly as channels of communication with the main committees of the College, such as Education, Training, Professional Standards, Scientific, etc."

Changes in structures and processes

No organisation which had not previously had a Scottish body had yet created one, though several had strengthened existing offices by appointing new staff or by improving premises. The Royal Society of Medicine, which did not envisage creating 'regional' offices, proposed to hold meetings in Cardiff, Edinburgh and Dublin. The anaesthetists, with a long-standing Scottish standing committee, did not envisage setting up an office to support this, mainly on the grounds that it was not clear how many specifically Scottish issues would arise and that any such office would inevitably cost money. They added that there had never been any pressure in Wales or Northern Ireland to establish local representation.

Several organisations already saw the possibility of extending or otherwise modifying existing arrangements. The paediatricians had been discussing the establishment of separate offices in Scotland, Wales and Northern Ireland. The RCN anticipated devolving greater authority to its Scottish, Welsh and Northern Irish boards, although this would require changes in the RCN's constitution and, as a preliminary to this, consultation with

members. The RCN was also consulting its members about possible changes in relation to England. The GPs' working party concluded that several continuing functions and activities made necessary a body at UK level, on which all four countries would be represented. It went on, however, to discuss the case for creating a separate English 'council' to match the existing councils in Scotland and Wales and a probable new council in Northern Ireland. In an interesting passage the group's report outlined the arguments for and against an English body; the former included:

This is an appropriate opportunity to grasp the nettle of the spirit of devolution as well as the mechanics....

It would appear arrogant to assume that English healthcare issues will always lead and be prominent even though members in England are by far the greatest proportion...

The UK Council could be poorly placed to respond to the English health care agenda if it is occupied with all the functions [which can be discharged only at UK level]...

The working group concluded that the status quo was unsustainable; it recommended to the College Council that the creation of an English Council should form part of the overall package of reforms contemplated.

The group went further in discussing the case for a new *sub-national* structure. The drivers for this were seen as including "emerging regional agendas in the health service and for example in England the development of PCGs [primary care groups] and PCTs [primary care trusts]". They invited the Council to advise on the best structures at sub-national level.

The BMA had revised the constitutions of its Scottish, Welsh and Northern Irish Councils, "to reflect the need for more robust representation of doctors in those areas"; some of its committees representing individual groups of doctors had set up English committees as well, in addition to existing UK committees. The BMA had also created new posts in the three country capitals, for example parliamentary officers and press and media staff. Speech and language therapists had agreed to appoint a part-time officer in Scotland for two years, "to give a quick response to documents and to advise the professional body in London". The Royal Society of Medicine proposed to extend its academic conference activities so as to run meetings in Cardiff, Edinburgh and Dublin, and was investigating the possibility of closer links with medical organisations in those regions. The ophthalmologists, who already had Welsh and Scottish committees, had offered to set up a similar committee for Northern Ireland "should that be deemed necessary". The president of one college noted that in Scotland many professional groups were "rushing about to get ready for something. I'd rather wait till we are clear what that 'something' is."

The dentists, however, had no immediate plans to make any changes to their existing centralised structure. The Royal Society of Medicine did "not envisage any regional

outposts of the Society even though we shall continue to organise meetings and promote our aims in Scotland and Wales.”

Challenges

Several organisations saw the main possible challenge as being ‘fragmentation’, and consequent divergence between the four countries in matters as various as training policy, clinical practice, staffing arrangements and terms and conditions of professional service. The GPs observed that the net effect of devolution and its consequences “*must therefore be increasingly divergent health care systems within the countries of the United Kingdom.*” [italics added]. The pathologists feared that the separate Scottish, Welsh and Northern Irish health services might:

become too parochial, seek to become wholly self-sufficient and thus run the risk of becoming isolated from what is happening in England. There are many areas where it is necessary to maintain UK wide arrangements for the provision of services. In the laboratory disciplines it is ... essential that on matters of training, workforce planning, quality assurance, accreditation, clinical governance, etc. the same standards should be met in all laboratories in the UK.

The ophthalmologists hoped “that national standards...will continue to be regarded as important.” The RCN also felt it important not to let Scotland go its own way on key issues, such as maintaining the post of Director of Nursing in NHS Trusts.

Problems

Some organisations foresaw devolution as likely to cause difficulties for themselves. This might be, as one college put it, in generally generating “waves of uncertainty in the short term”. Another suggested that:

uncertainty as to the relationship between the NHSE and the health service will cause short/medium term problems which will need to be resolved. The College will wish to discuss issues with those who have the ability to change matters. The problem will be in determining who that will be.

Devolution could also make it hard to keep close to four separate governments, legislatures and health services and to devise consistent national policies that took adequate account of differences between national services - especially if, as one royal college put it, “Scots assembly members will not have much else to talk about and so there’s a risk that they may want to start doing things differently”. The GPs, in a letter from the chairman of their working group, expressed both these points very clearly:

The planned way of working in Scotland with policy development in co-operation with special interests such as the medical profession will mean that

there is a greatly increased need on our part to inform and influence discussion. This in turn will require a much enhanced infrastructure and considerable professional time; putting strain on the relatively small professional resources in these parts of the UK. [...] The second challenge may be the co-ordination of the College's response to the various systems to ensure that it retains a consistent set of UK policies while responding to presumed increasingly diverse healthcare systems.

The pathologists put a related point even more bluntly:

London-based Colleges such as this one could become marginalised and its influence diminished if the Scottish Affairs Committee were to be driven by the Scottish Health department to act as the national (Scottish) spokesperson for the pathology disciplines.

The RCN saw a major challenge in responding quickly enough, as a UK organisation which had traditionally taken a 'UK line', to developments in individual devolved administrations and to the desire of local elected representatives for an immediate response. They felt that there was nothing intrinsically wrong in divergence among the different countries; in the past, many UK government policies and pronouncements had been quite inappropriate in particular locations. But national bodies would have to modify their own practices to take account of local variance: to be an effective four-country organisation, the RCN might need to improve their own systems for informing the centre about local developments.

Another college, by contrast, expressed some anxiety about the possibility, however remote, that the Welsh health service might decide to diverge from accepted UK policy in relation to certain services. They felt that in such a case their own Welsh committee would probably argue the case for maintaining the existing policy and for not trying to develop a Welsh variant. In this kind of context the college as a whole would probably act as a force for uniformity.

A different college expressed a rather different kind of anxiety about one possible consequence of increased autonomy for Scotland. There was an existing and perennial problem, as they saw it, of over-supply of Scottish training places in their profession. The Department of Health had never made it clear how many consultant posts were envisaged in their plans; although the Scottish health department had recently stated that they would reduce the number of training places the extent of this cut remained equally obscure. If in future the Scottish NHS were to become totally independent, there could be a massive over-supply of trained professionals from Scotland.

Only one college identified, as a possible challenge, differences of attitude within their own membership. The college would have to work:

to retain the enthusiasm and support of the devolved areas [. . .] These seem to be looking for major changes to our constitution while the majority may regard

the status quo as being preferable.

The European Union

At this stage, few organisations envisaged any specific changes or problems in their working relationships with institutions in Brussels. Many did not consider this dimension even worth mentioning. The speech and language therapists saw no major problems in principle, but felt that they would “struggle with competing agendas and difficulties are envisaged for the profession.” On a rather different point, the ophthalmologists saw “scope for difficulty if one country in the United Kingdom develops its policy on a European Union directive in a different style to the others.”

Intergovernmental Relations

Devolution has changed the way the United Kingdom is governed. Where before there was a single government in Whitehall, there are now four, although the powers of each differ. One consequence of this is the emergence of a new series of activities at the heart of the governance of the United Kingdom, to which the term ‘intergovernmental relations’ has been applied.

Devolution has widened the political context to policy co-ordination in the UK and brings the potential for policy divergence between the different administrations. To the extent that such policy divergence enables administrations to address local needs and priorities it is to be welcomed. But:

Without close co-operation between all four UK administrations there is the risk that developments in one administration may inadvertently constrain or put pressure on policy or finances of other administrations.⁶⁰

Early in the preparations for devolution it was recognised that some conventions would be needed to assist the conduct of these activities. As a result agreements have been reached, and mechanisms put in place, to assist the conduct of intergovernmental relations.

The devolved executives are not bound by UK Government collective responsibility and their Ministers cannot therefore serve on UK Cabinet Committees. A consultative Joint Ministerial Committee (JMC) chaired by the UK Prime Minister will meet in summit and functional formats on reserved matters affecting devolved matters and on devolved issues of common concern.

Key documents describing administrative co-ordination mechanisms include a Memorandum of Understanding, supplemented by overarching ‘concordats’, between the

⁶⁰ Department of Health *Concordat on Health and Social Care, 1999*

four governments. Beneath this, at Departmental level, concordats have been negotiated between the different administrations. While the majority of these concordats are bilateral between the relevant administrations, the Department of Health has opted for a single concordat agreed with all the devolved administrations.

The rule is 'no surprises'. The *Concordat on Health and Social Care*:

is intended to provide a framework for co-operation between the Department of Health and the departments or directorates concerned with health and social care in each of the devolved administrations.

The general principle underpinning the *Concordat* is that:

The parties jointly affirm their commitment to co-operate on matters affecting the NHS, public health, wider health issues and social care, seeking to work in an open and helpful manner, with good communication and early involvement of the other parties when appropriate. This will build on existing working relationships, with officials continuing to maintain free, informal and regular contact.

Concordats are not contracts and they do not create legal obligations or restrictions on any party. However, it is the intention that the devolved administrations and the Department of Health will manage their business with regard to the *Concordat* wherever possible. While every effort will be made to avoid disputes, should one arise which cannot be handled by the officials concerned, it will be considered first by senior officials and then, if need be, by the relevant Ministers or Assembly Secretaries to seek a mutually acceptable resolution. Referral to the Joint Ministerial Committee will be the option of last resort.

Europe

In the Devolution and Health report, we identified transactions with Europe as a particularly problematic area, given the aspirations of the different countries. On EU matters, the UK remains the Member State but the intention is that the devolved administrations will be as fully involved as possible in formulating the UK's negotiating position. The devolved legislatures will be able to scrutinise EC proposals, although there are indications that they may have difficulty in doing so in the time allowed. Early indications are that some of the administrations will take longer to go through processes of consultation than is the norm at Westminster.

By their very nature, intergovernmental transactions are hard for those outside the administrations concerned to observe and monitor. Even if this were not the case, it is too early to try to draw many conclusions from what has happened so far. There appear to have been relatively few policy areas where the potential for policy divergence has exhibited the

negative consequences described above, and those that have arisen are not in health but other areas. The dispute reconciliation machinery therefore is relatively untested. Yet what has happened has demonstrated the potential for difficulty in future.

Devolution has changed the nature of problems faced by the administrations. Prior to devolution, there were many issues which could be termed *administrative problems* which were handled by the civil servants concerned - often, one suspects, without Ministers being aware of the difficulties and certainly without them being involved. But post-devolution, many of these have changed from being administrative issues to *political problems* - that is, matters on which political advice has to be sought, or political judgements made. The civil servants concerned face a fairly steep learning curve in adjusting to this change, as do the politicians. And while concordats may assist in influencing administrative dealings between governments, it is less clear that they can influence political processes. One senior civil servant, close to the conduct of inter-governmental relations, characterised the conduct of business in 1999 as involving a considerable amount of 'muddling through'. If so, it is to the credit of those involved that it has been achieved successfully. But, for the issues of governance and accountability which are our main concern in this project, future developments in this area will be of major significance.

Concluding Remarks - looking to the future

Introduction

At the end of the first year of this monitoring project, what are the main conclusions, and what does the future hold? As the preceding sections have shown, the year has produced little in terms of health policy divergence that can be directly laid at the door of devolution. Nor have there been major difficulties in the conduct of inter-governmental relations in health, or obvious conflict over any of the issues identified as problematic in our original Devolution and Health report. 'Small war; not many dead' might be the first dispatch from the devolution and health front line. And yet, this might be a misleading impression.

What has been happening in health? In the three countries that comprise Great Britain, the administrations have been working to implement health policies developed by the Labour government when it came to power, using the existing processes of administrative devolution. The different countries' White and Green papers had set out challenging agendas which would not be implemented overnight. So it is not surprising that we have yet to see any major new health policy initiatives introduced by one or other of the devolved administrations.

But already the ways the health services are delivered in the three countries are starting to look increasingly different. Trust reconfiguration in Wales has combined acute and community service providers into 'integrated' or 'whole district' trusts. In Scotland there is only one remaining integrated trust, with most Scottish Health Board areas having one acute trust and one primary care trust. Northern Ireland is still discussing the implementation of a plan prepared before devolution to rationalise the acute sector, but if implemented this would mean the majority of Trusts being integrated, with only one remaining acute trust and one remaining primary care trust.

Differences are emerging particularly in primary care. Scotland has opted to move immediately to the establishment of primary care trusts (PCTs) unlike England where there is a staged approach. Also different from England is the fact that PCTs do not undertake commissioning of services. Scottish PCTs tend to be bigger than their English counterparts, and within each PCT's area there are a number of Local Health Co-operatives that are the focal point for service development and which are expected to be drivers of change and innovation. Joint Investment Funds (JIFs) are a key feature of health service planning and policy in Scotland. Developed with the involvement of PCTs and Acute Trusts, these have brought about some significant shifts from the acute sector to primary care. Wales is organising its primary care through 22 Local Health Groups (LHGs), each co-terminous with a Local Authority. In Wales it is the LHGs that will develop relationships with the Trusts providing secondary care.

Scotland has a number of Personal Medical Service pilot projects which involve salaried General Practitioners, a development considered inevitable over the next 5-10 years given the demographics of the GP workforce. In Wales, GP membership of Local Health Co-operatives is voluntary, although around 85 per cent of GPs are members. All three countries of Great Britain have now abolished GP fundholding, although in Northern Ireland it will not disappear until 2001. Examples like these show how the organisation and management of health services is diverging, a trend which is expected to continue.

We cannot conclude this brief overview without a mention of England. We commented above on the centralised nature of the policy for the English NHS. Through most of 1999 the English NHS pursued the implementation of the policies outlined in the English White and Green Papers of 1998, which included a commitment to modernise the NHS, improve quality, and guarantee that services would deliver evidence-based medicine. This was coupled with an insistence on meeting the Labour government's election pledge of reducing waiting lists, a policy which had frequently been criticised by clinicians as distorting resource allocations and activity levels. The somewhat unexpected change of Secretary of State towards the end of the year brought a significant shift in policy thinking, with the improvement of the English NHS's poor performance at tackling the 'major killers', cancer and coronary heart disease, being identified as a priority.

Throughout the year, English press coverage of the NHS, particularly by the tabloids, became more critical and strident, with some headlines even talking of England's 'third world' NHS. The major crisis for the service caused by the influenza epidemic of December 1999 appeared to trigger a Prime Ministerial commitment to increase NHS funding in real terms year on year so that, in five years, the proportion of GDP spent on health would match the current European average. The extent to which this could be achieved without an increase in general taxation, as seemed to be implied, is still being debated as we write, as is the precise nature of the 'commitment' made. It seemed to go almost without comment in the English press that the NHS in Scotland had managed the influenza epidemic with rather less difficulty, and this was not linked in comment to the additional 23 percent per capita funding that the Barnett formula delivers to the Scottish block. (And yet, at around the same time the Home Secretary was speaking of his fears that devolution, in general, not just in health, might provoke an 'English backlash'!)

In terms of expenditure on health, any changes in English spending will be reflected in the block allocation to Scotland, Wales and Northern Ireland. Depending on overall changes in spending, the other UK countries may not find it either easy, or perhaps necessary, to accommodate the increases in spending implied in the Prime Minister's statement. The difference between 'the NHS' and the national health services in Scotland, Wales and Northern Ireland may begin to impinge more sharply on the public's consciousness in the

next few years.

So, as the devolution process unfolds, what are the implications for our primary concerns about governance and accountability?

Governance and accountability in the United Kingdom Health Services

In general, discussions of health in the three countries has focused mainly on the substance of health policy, and on their health status – relatively poor by UK and European standards. The main issues of interest to this study – governance and accountability – have so far attracted little public attention per se. However, in some of the autumn debates in the Scottish Parliament references to these issues remind us that, in a democracy, they can never be far from the mainstream.

Thus, in her opening speech in a debate last December, the Minister for Health and Community Care (Susan Deacon) made some remarks which went to the heart of the rationale for devolution. She would work, she said:

“to bring about a step change in the way in which the NHS...communicates and engages with the wider public. The NHS belongs to the people of Scotland. They must feel that it does.... Local communities and local elected representatives have a right to know who takes decisions and why they are taken and must have the opportunity to contribute to the decision-making process.”

She said that she would write to elected Members of all parties to ask them to suggest local people as members of NHS boards.

Later in the debate a Conservative Member protested about inadequate consultation on changes in health services. A Labour Member declared that “the days of decisions being made in closed rooms are finished. The NHS is open and accountable.” A Liberal Democrat Member said that though Ministers must make decisions, “The views of the people who use the health service should be taken into account at all times.” The Deputy Minister, winding up, repeated the point that the Administration’s initiatives “are about Scotland and are accountable to Scotland.”⁶¹

The point is, of course, that if the Administration does in fact act effectively on undertakings of this kind, democratic process and policy substance will become inextricably intertwined. The rhetoric says that if the people of Scotland, Wales or Northern Ireland decide that they need and want health services of a kind different from those which, until now, have been planned and delivered by a UK government, they will get such services. That possibility is

⁶¹ Scottish Parliament, *Official Report* vol. 3 no. 16 cols. 1705-1743

central to the objectives of devolution. The aim of this study is to monitor how far the possibility is realised in practice.

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Health Boards and Trusts (Scotland)

Argyll and Clyde Health Board	0141-842-7200
Renfrewshire and Inverclyde PC Trust	0141-884-5122
Lomond and Argyll PC Trust	01546-606600
Argyll and Clyde AH Trust	01389-754121
Ayrshire and Arran Health Board	01292-611040
Ayrshire and Arran PC Trust	01292-513600
Ayrshire and Arran AH Trust	01292-614510
Borders Health Board	01896-825500
Borders PC Trust	01896-828282
Borders General AH Trust	01896-754333
Dumfries and Galloway Health Board	01387-272700
Dumfries and Galloway PC Trust	01387-244000
Dumfries and Galloway AH Trust	01387-246246
Fife Health Board	01334-656200
Fife PC Trust	01592-712812
Fife AH Trust	01383-623623
Forth Valley Health Board	01786-457249
Forth Valley PC Trust	01324-404083
Forth Valley AH Trust	01324-570700
Grampian Health Board	01224-663456
Grampian PC Trust	01224-663123
Grampian AH Trust	01224-840586
Greater Glasgow Health Board	0141-201-4444
Greater Glasgow PC Trust	0141-211-3000
North Glasgow AH Trust	0141-201-3000
South Glasgow AH Trust	0141-201-1100
Yorkhill AH Trust	0141-201-0000

Highland Health Board	01463-717123
Highland PC Trust	01463-242860
Highland AH Trust	01463-704000
Lanarkshire Health Board	01698-281313
Lanarkshire PC Trust	01698-245000
Lanarkshire AH Trust	01698-747292
Lothian Health Board	0131-536-9000
Lothian PC Trust	0131-537-9525
Lothian AH Trust	0131-536-1000
West Lothian PC Trust	01506-419666
Orkney Health Board	01856-872763
Shetland Health Board	01595-696767
Tayside Health Board	01382-561818
Tayside PC Trust	01382-423000
Tayside AH Trust	01382-660111
Western Isles Health Board	01851-702997

Scottish Ministers and Party Shadows*Ministers*

Donald Dewar	First Minister
Jim Wallace	Deputy First Minister and Justice
Wendy Alexander	Minister for Communities
Sarah Boyack	Minister for Transport and the Environment
Susan Deacon	Minister for Health and Community Care
Ross Finnie	Minister for Rural Affairs
Sam Galbraith	Minister for Children and Education
Lord Hardie QC	Lord Advocate
Tom McCabe	Business Manager
Henry McLeish	Minister for Enterprise and Lifelong Learning
Jack McConnell	Minister for Finance

Party Shadows

Kay Ullrich	SNP	Health and Community Care
Mary Scanlon	Conservative	Health (inc. Social Work)
Robert Brown	Liberal Democrat	Health, community Care and Housing

Composition of the Health and Community Care Committee (Scotland)

Convenor: Margaret Smith

Committee Members:

Malcolm Chisholm
Dorothy Grace-Elder
Duncan Hamilton
Hugh Henry
Margaret Jamieson
Irene Oldfather
Mary Scanlon
Richard Simpson
Kay Ullrich
Ben Wallace

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Table 4: - Welsh Health and Social Services Spending Plans 1999-2002 £ million⁶²

	1999-00	2000-01	2001-02
Health Authorities and Trusts	2,216.4	2,361.8	2,508.3
Education and Training	82.6	85.6	88.3
Family health Services (e.g. funding contractors)	276.6	292.8	310.2
Health improvement	6.4	14.6	15.1
Health promotion	1.8	2.6	2.9
Food standards	0.6	0.5	0.5
Welfare food	12.9	12.9	12.9
Children	8.8	17.7	17.7
People in Communities	1.8	1.8	1.8
Social inclusion	8.4	11.2	31.5
Support for voluntary sector	5.0	5.0	4.6
Social Services Inspectorate	4.9	5.2	5.3
Other health & social services	52.1	50.0	50.1
Personal social services credit approvals	6.5	6.5	6.5
TOTAL	2,684.7	2,868.1	3,055.5

More broadly, an impression of the current key targets for improvement in Wales health and social services is provided in Table 5 on the following pages.

⁶² Source: *A Better Wales, National Assembly for Wales, A consultation paper on values, service priorities and spending plans*, July 1999

Table 5: Welsh Health and Social Services : Key Targets and Performance⁶³

Sub-objective	Measure	Position In 1997-98 unless otherwise stated	Target 1998-99 unless otherwise stated	Forecast outturn For 1998-99 targets
To improve the health & well-being of the population of Wales Reduce inequalities in health status	Reduce deaths from lung cancer for people aged under 75 For men: For women:	49.2 per 100,000 in 1995 23 per 100,000 in 1995	54 percent by 2010 21 percent by 2010	44.5 per 100,000 in 1997 22.9 per 100,000 in 1997
	Reduce deaths from breast cancer for women aged 50-74	83.9 per 100,000 in 1995	30 percent by 2002	82.2 per 100,000 in 1997
	To reduce inequality in access to health services & treat people suffering from illness or injury effectively	Reduce deaths from coronary heart disease for people Aged under 65: Aged 65-74	50.3 per 100,000 in 1995 820 per 100,000 in 1995	50% by 2002 25% by 2002
Reduce deaths from strokes for people: Aged under 65: Aged 65-74		11.5 per 100,000 in 1995 218.4 per 100,000 in 1995	20% by 2002 25% by 2002	12.2 per 100,000 in 1997 213.6 per 100,000 in 1997
Reduce registrations for cervical cancer:		21.9 per 100,000 in 1990	50% by 2002	11.5 per 100,000 in 1994
Reduce the proportion of people aged 18-64 who drink more than the sensible limit (21 units per week for men & 14 for women) Men: Women		26.4% in 1993 8.5% in 1993	18% by 2002 7% by 2002	27.4 per 100,000 in 1996 11.2% in 1996
Reduce waiting lists to below their March 1997 level		-	By March 1999 (i.e. to 67,000)	71,264 at November 1998

⁶³ Source: Welsh Office's Departmental Report, April 1999.

Table 5 cont.: Welsh Health and Social Services : Key Targets and Performance

Sub-objective	Measure	Position In 1997-98 unless otherwise stated	Target 1998-99 unless otherwise stated	Forecast outturn For 1998-99 targets	
To improve standards of support & care provided in the community to the socially disadvantaged or those requiring continuing care	Percentage of Community Care Assessments resulting in residential / nursing home care	16%	14%	N/A.	
	Percentage of Community Care Assessments resulting in domiciliary care packaging	84%	86%	N/A.	
	Mental health (increase mental component summary score)	49.5%	50% by 2002	-	
	Number of people in long-stay mental handicap hospitals	607	500	N/A.	
To promote the welfare of children and to protect them from abuse and neglect	Proportion of women who give up smoking whilst pregnant		33% by 2002	-	
	Proportion of low weight births (under 2,500 gms)	7.2% in 1996	Below 6% by 2002	-	
	Proportion of 15-year olds who smoke at least weekly	boys	23% in 1996	16% by 2002	-
		girls	29% in 1996	20% by 2002	-
	Proportion of 5 & 14-year olds experiencing dental caries	5 year olds	57%	48% by 2002	-
		14 year olds	64% in 1994-5	59% by 2002	-
	Number of children looked after by local authorities (per 1000 under 18)	4.4 in 1996	4.4	N/A.	
Number of children on the Child Protection Register (per 1000 under 18)	3 (March 1997)	3	N/A.		

Table 7: Draft Budget Approved by the Assembly in Plenary Session on 1 December - Main Expenditure Groups (£000s)

	2000-01			2001-02		
	Initial Changes ¹	Approved Changes ²	Approved Plans	Initial Changes ¹	Approved Changes ²	Approved Plans
Health and Social Services	12,100	12,100	2,880,162	10,100	10,100	3,065,622
Local Government	16,140	16,740	2,693,305	36,908	36,908	2,820,457
Housing, Transport and Environment	2,600	2,600	714,561	6,050	6,050	733,130
Agriculture and Rural Development	5,600	5,880	282,746	5,500	5,500	307,007
Economic Development	-6,600	-6,203	315,468	-11,600	-11,352	329,999
(ED including ERDF carried forward)	(49,400)	(49,400)	(371,071)	-	-	-
Education and Training	-13,655	-12,766	882,675	-29,218	-28,474	932,921
(E&T budget pre transfer to Local Government)	(835)	(2,324)	(897,765)	(6,040)	(6,784)	(968,179)
Chief Inspector of Schools	0	0	9,509	800	800	10,566
Auditor General for Wales	1,551	1,551	1,961	1,651	1,651	2,061
Assembly Costs	0	0	26,822	0	0	22,173
Central Administration	0	0	101,904	0	0	108,688
Capital Modernisation Fund/Invest to Save Budget	-17,936	-17,936	115	-20,391	-20,391	345
TOTAL ASSEMBLY EXPENDITURE	-200	1,966	7,909,228	-200	792	8,332,969
Office of the Secretary of State for Wales	200	200	2,862	200	200	3,096
TOTAL WELSH BUDGET	0	2,166	7,912,090	0	992	8,336,065

1. Initial Changes are the changes, relative to the inherited Welsh Office plans, set out in the Preliminary Draft Budget of 4th November 1999.
2. Approved Changes are the changes, relative to the inherited Welsh Office plans, which were accepted in the Plenary debate of 1st December 1999.

Devolution Comparison of Legislative Competences in Health

WESTMINSTER	STORMONT	HOLYROOD	CARDIFF
Regulations of the Health Profession	☆	X	X
Abortion	=	X	X
Human Fertilisation & Embryology	=	X	X
Surrogacy	=	X	X
Human Genetics	=	X	X
Xenotransplantation	=	X	X
The Medicines Act 1968			
Licensing	☆	X	X
Regulation	☆	X	X
Enforcement	☆	☆	☆
Medical Devices Regulation	=	X	X
Pharmaceutical Price Regulation Scheme	☆	X	X
Welfare Foods			
Policy	☆	X	X
Administration	☆	☆	☆
EU Relations	Excepted	X	X
International Relations	Excepted	X	X
Policy and Management of the NHS & Health Services	☆	☆	☆
Policy and Management of the Social Services	☆	☆	☆

Key:

- ☆ Devolved, executively devolved or transferred
- X Reserved to Westminster (Scotland); No Assembly competence (Wales)
- = Reserved but Assembly can legislate with Secretary of State approval and Westminster veto.