Invited Review

Devolution and health in the UK: policy and its lessons since 1998

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Abstract

Introduction: Since devolution in 1998, the UK has had four increasingly distinct health systems, in England, Northern Ireland, Scotland and Wales.

Sources of data: Secondary literature and authors' own research since 1998.

Areas of agreement: From a similar starting point, there has been a considerable distancing of the four health systems from each other in policies, priorities and organization.

Areas of controversy: The comparative efficiency and quality of the different systems as well as the wisdom of their greater or lesser reliance on integration and competition.

Growing points: Better and more comparable public data would be useful, as would consideration of potential devolved lessons for UK policy.

Areas timely for developing further research: Comparisons of organization and performance at levels more detailed than whole systems; analysis of the resilience and management of different systems in a context of budgetary austerity; analysis of the politics behind policy decisions.

Key words: NHS, policy, England, Northern Ireland, Scotland, Wales

There are few natural policy experiments as intriguing or potentially useful as that provided by the four health systems of the UK. The UK's four

systems were created very similar at the high watermark of British political unity. They were all 'national health service' (NHS) systems, with the

government directly owning hospitals, contracting with primary care General Practitioners (GP) and employing most other staff in a system centrally financed out of general taxation and provided for free at the point of service. The Welsh NHS was only carved out of the English NHS in 1969. Scotland's NHS was born at the same time as the English NHS in 1948, and its institutional differentiation was limited. Northern Ireland's NHS system was merged with the broader social care system, called 'Health and Social Care' (HSC) system rather than NHS, but it is clearly part of the NHS family of systems. As ideal types of NHS systems, they have all the advantages (relatively easy service integration, low costs, effective gatekeeping and planning by international standards) and all the disadvantages (vulnerability to underfunding, centralization and endless reform).

There are a number of book-length comparisons of devolved health policy and politics¹⁻⁵ as well as an impressive collection of comparative data⁶ and various studies of individual topics.⁷⁻¹⁰ All four UK health systems have lively health research communities that often use data from sites in those different systems.

What is devolution?

Devolution meant the creation of autonomous, elected, governments for Northern Ireland, Scotland and Wales.^{11,12} It is a highly asymmetric arrangement in which the UK government is responsible for not just shared policies such as defence, but also the public policies of England such as health care. Part of the reason such an arrangement works is that England makes up ~85% of the UK's population and economy and therefore dominates the UK government that runs England. Devolution often means that Northern Ireland, Scotland and Wales can avoid policies whose support is largely confined to England.

Most money is raised by the UK and distributed according to the 'Barnett formula'. This relates devolved block grants to the expenditure on English comparable services that are devolved outside England. Barnett gives devolved governments a share of new expenditure in proportion to their population vis-à-vis England's (so for every new

pound of expenditure on comparable services in England, Scotland gets about 10 pence).

The devolution 'settlement' is particularly unsettled at the moment, even if Scotland's 2014 independence referendum led to a victory for those who wanted to stay in the Union. There are increasing tax raising powers for Scotland and potentially Northern Ireland and efforts to make the UK government's English policies answerable only to English MPs.

Devolution and health policy: a short history

At the time of devolution in 1998, many people expected that the newly autonomous political systems of Northern Ireland, Scotland and Wales would continue much as before, with local variations on English policies. They were wrong. The tendency to view Welsh health policy as a bilingual copy of English policy, or Scottish policy as a 'kilted' version of English, was born of the long years before 1998 when Northern Ireland, Scotland or Wales were mostly implementers of UK policies designed with England in mind. They were distinctive, but they were distinctive at the margins. Political devolution gave their local political systems and policy debates the autonomy to choose different policies, and they rapidly did.

By 2003, the second set of devolved elections, the autonomy that came with devolution had produced four quite strikingly different approaches to health policy.^{2,13} Broadly, English policy made by the UK government emphasized choice and competition, seeing the NHS as something that needed competition and management to produce customer satisfaction. This thinking, which Tony Blair's advisor Simon Stevens formalized into an ideology of 'constructive discomfort',¹⁴ produced all sorts of changes, from Foundation Trusts to greater use of the private sector and a number of new NHS regulators. Scottish policy was much more consistent, consensual and professionally dominated, with an ideology of partnership and mutuality to counter English competition thinking and a much greater focus on 'Cinderella' issues like mental health care. Scottish policymakers gradually integrated more and

more of the NHS into territorial boards with broad responsibilities. There was much continuity from the first-ever Scottish health White Paper in 1998 until today despite changes in government.¹⁵ Welsh health policy was more radical, with an explicit effort to de-emphasize health care, particularly targets and shibboleths like waiting times, and refocus on intersectoral work for public health. It included a reorganization that produced 22 Local Health Boards coterminous with local government responsible for primary care and commissioning from seven trusts. Northern Ireland's health policies, finally, reflected Northern Ireland's political system, and few people go into Northern Irish politics because they want to make a mark on health care or public health. The sectarian party system and veto-ridden political structure of the Northern Ireland executive, combined with periodic brinkmanship over constitutional issues, all mean that health policy often goes ignored. The result was drift and conflict-avoiding managerialism in a remarkably overgrown administrative environment of 37 different HSC quangos.

These four models were all free to evolve in the context of growing resources (until 2010) and all the democratic accountability that devolution brought. The result was that they all began to be modified with time. Devolution was not only about autonomy. It was also about democratic responsiveness, and from about 2003 policies were shaped by voters' clear opinions on issues from waiting times to the threat of Methicillin-resistant *Staphylococcus aureus* (MRSA) to the eternally infuriating topic of parking charges at NHS facilities. All four UK systems found that while voters might reward variations such as free prescriptions or universal long-term care for the elderly, they would also punish politicians associated with poor quality or long waits.¹⁶

If the first wave of policy reforms after devolution, then, reflected the new autonomy of devolved political systems and all the pent-up reform ideas that were irrelevant under 18 years of UK Conservative rule, the subsequent reforms began to reflect the challenges of running health services that would please voters. It was after 2003, after devolution was well entrenched, that we began to see convergence on what we might call a 'devolved model' of NHS policy. Northern

Ireland, Scotland and Wales all developed policies and models of public services that looked increasingly similar, while England, under the UK government, went its own way.

Over time, English divergence has put strains on shared institutions. Notably, devolved governments initially all agreed to UK-wide contracts with NHS staff. The experiences of very expensive doctors' contracts agreed by the UK government in 2005 convinced many devolved policymakers that sticking with the UK government was unwise. They have been increasingly divergent, since, balancing the benefits of consistent UK-wide conditions with the desire to avoid being caught up in English health policy agendas.

The devolved models

The core of the model that Northern Ireland, Scotland and Wales all share now is a basic integrated structure with territorial organizations that organize and provide integrated health services in their area. The divide between purchasers of care and providers of care that has been the core of English health policy since 1989 is gone in Scotland and Wales. Instead, these large boards are the focus of policy and planning. The result is a relatively flat and simple system with accountability focused in boards, which are then accountable to the minister. Scottish commitments to mutuality and voice as an alternative to English competition, and Scottish experiments in public participation also produced a debate about whether they changed the way health systems worked.^{17–19}

Northern Ireland²⁰ has a different structure which preserves the purchaser–provider divide, but locates the centre of gravity of the system in five big HSC trusts that are all commissioned by a single board for the whole of Northern Ireland, which functions like an arm of the health department. The combination of the trusts, which are large integrated territorial monopolies, with commissioning for the whole of Northern Ireland means that commissioning is better viewed as simple planning. The retention of the purchaser–provider divide is largely a distinction without a difference.

What might explain this convergence on the model of integrated territorial provision? There is

no particular evidence that devolved policymakers tried to emulate each other. Rather, they seemed to have converged in a process of learning and problem-solving that led them to similar solutions.

First, there are a variety of technical reasons. Integrated territorial provision requires less staff. When Wales had 22 local health boards and 7 trusts, it required 29 NHS finance officers. Since its 2009 reforms, it requires 10 (7 for its large integrated local health boards and 3 for special trusts such as the ambulance service). Northern Ireland once had to staff and coordinate 37 HSC organizations for a population of 1.8 m (smaller than Greater Birmingham). Now it only has six. Not only does this model entail savings from fewer executive position but also makes it easier to hire. One cannot assume an infinite supply of capable NHS managers.

The case for fragmentation, particularly the division between trusts and local organizations that commission from them, largely depends on the case for competition. Provider competition has tended not to be adopted or work well in the devolved administrations. The reasons are difficult to parse out and the last real experiment in competition outside England was in the 1990s, but it seems that the reasons are similar to the reasons why it tended not to work well outside London and Southeast England: lack of a strong private sector, reasonable satisfaction with services and a population said to be less likely to want to shop around. Devolved governments saw no reason to maintain structures that assumed competitive markets which had never worked well and no longer had political support (every UK government but the Welsh had a great affection for private finance (PFI) contracts, many of which have not been good value).

Finally, there are issues of size. While transportation can be highly inconvenient in all three devolved jurisdictions and local communities highly mobilized, they are still relatively small political systems and health economies. Inevitably, planning and management for a population of 5 million or less will tend to be centralized, since 5 million is around the minimum to sustain many specialist services. If much health care must be orchestrated centrally,

then the case for multiple layers of management is diminished.

The English approach

England differs from the three devolved jurisdictions in a number of ways. Not only is it a far larger political system and NHS, its politics also include a much stronger Conservative party with a weaker attachment to public services including the NHS, and it has a long-standing set of assertive advocates for the introduction of more management and competition into the NHS.² The standing of the NHS is not as solid in England as it is elsewhere, and as a result even pro-NHS politicians are constantly seeking ways to make it show its usefulness through high customer satisfaction.

The English NHS has been so constantly, and consistently, reformed that it is difficult to pick out individual reforms that mattered most. The constancy of reform is impressive. Apart from big reforms, such as Thatcher's internal market, Blair's 'NHS Plan'²¹ and Shifting the 'Balance of Power',²² and Andrew Lansley's reforms under the Coalition,²³ there has been a constant flow of changes to almost any aspect of the Service, both formal (as with the mergers and creations of different quangos) and less formal (as with the evolving priorities and relationships between big NHS organizations such as the financial regulator Monitor and the commissioning NHS England). The English NHS has been in constant organizational flux, with detrimental effects, since at least 1997.

The consistency of the reforms might be less apparent to people in the NHS, but they mostly pursue a trajectory towards greater management and greater markets.^{24–26} Various governments, Labour, Conservative and Coalition, have been avid consumers of international ideas for health systems reform including performance and clinical data collection, private sector and internal public sector competition, quality and competition regulation, professional management, performance management targets and specialist quangos for issues such as care quality or patient safety. As they built up a range of central tools to intervene in the NHS by sculpting its markets and management, the older layers of NHS

management began to seem superfluous or even unhelpful. Thus, NHS regions, once keystones of the system, joined professional-dominated ‘consensus management’ in the history of the NHS, and the centre of the system filled with increasingly managerial specialist organizations such as the Care Quality Commission and the financial regulator Monitor.²⁷

The Lansley reforms passed by the Coalition²³ took the logic of markets and management that had characterized English policy since Thatcher, and especially under Blair, to an extreme. The Coalition drove a spectacularly disruptive reform that nonetheless had conceptual continuity with previous policy.²⁸ They abolished the previous regional levels of performance management and instead created a two-tier English NHS. Local groups of GPs would commission care from foundation trusts, with care quality regulated by the Care Quality Commission and finances regulated by Monitor. NHS England would commission on a national level. This system had a variety of tensions, but the notable change is that it has little place in its governance for professionals or intermediate managerial levels. It was a vision of an NHS that worked like the mobile telephone or utility markets, with national regulators overseeing a market. Increasing austerity and internal tensions meant that the system never even started to work in the manner Lansley appeared to intend but is an obstacle to integrated working.²⁹

Against this backdrop of centralization and market-making, there has been a resurgence of interest in a greater local government role in the NHS. The clearest possibility for further devolution lies in the important issues surrounding the integration of NHS health and local authority social care.^{30,31} Greater Manchester and NHS England have agreed to merge the two budgets into a Greater Manchester Health and Social Care Board composed of an integrated Joint Commissioning Board that will negotiate with members of an Overarching Provider Forum. Governance will be ‘diffuse’ and incorporate substantial central control via seats on the Board and funding constraints, but compared to existing English local government, it is an impressive degree of autonomy, size and integration with health.³² The Manchester model and

subsequent proposals do not address the decreasing central government funding of social care or affect the broader benefits agenda of the UK government and the head of NHS England has said ‘not many’ other parts of England are likely to have such arrangements.³⁰ The historical instability of English regional government and NHS management structures, both of them repeatedly reorganized by central government, is another reason to worry about the ultimate meaning and sustainability of these developments.

Beyond healthcare delivery

Health care is no island. Demand for health care is substantially affected by the success or failure of public health and social care policies. The differing organization of public health and social care around the UK affects health and health care, in particular by allocating key responsibilities in some places to local governments that are under intense budgetary pressure and whose politicians might not have much incentive to spend limited budgets on social care or public health.

Public health

Public health has seen many of the same focuses and limitations in all four jurisdictions, probably reflecting shared socioeconomic circumstances and problems such as income inequality.³³ There was some devolved initiative in the movement to ban smoking in public places, there were a variety of experiments in addressing social determinants of health in Scotland and Wales, and now the Scottish Government is trying to institute minimum alcohol pricing (since the UK declined to devolve the power to establish a separate Scottish excise tax power on alcohol).³⁴ The compatibility of the Scottish initiative with EU law has been challenged and a case is pending (Case C-333/14 before the Court of Justice of the European Union).

Organizationally, the key difference is that the devolved governments all centralized the public health function into single agencies: NHS Health Scotland, Public Health Wales and the Public Health Agency in Northern Ireland. England, in the

Coalition reforms, went in the opposite direction. It created a small centralized Public Health England, largely out of a pre-existing Health Protection Agency, but transferred most public health staff and funds to local governments. The effect has been variation in public health power and priorities from one local authority to another, and increased exposure of public health work to local budgets that are absorbing increasingly deep cuts.

Relations between the health service, benefits and social care

Effective social care can both keep vulnerable people out of hospital and get them out of hospital quickly. Effective social care is also, however, very expensive and suffers from a variety of problematic political incentives. In England (outside Greater Manchester), Scotland and Wales, social care is a responsibility of local government, which has a politics and culture very different from the NHS. This means that local governments under serious spending constraints have incentive to cut social care. The costs of such cuts are then borne by the health services. Temporary expedients such as allowing the NHS to fine local governments for 'delayed transfers of care' have limited the effect of this disjunction.

In Scotland, which already has universal long-term personal care for the elderly,³⁵ the solution so far has been to oblige local governments to work closely with NHS boards.¹⁵ The UK government has made some moves towards universal long-term care.³⁶ In principle, Northern Ireland's HSC system avoids the problems faced in Great Britain, but it has proven exceedingly difficult to reallocate funds from healthcare services to social care of any kind. Wales, meanwhile, has not protected its NHS budget as much as the others, but its social services budget has fared better.³⁷ The Welsh decision might mean benefits for the Welsh NHS and its users such as more patients in better-value social care rather than hospital beds.

There is no clear 'solution' to the problem of pressure on social care, but the management of the interface between social care and health care is becoming more difficult with austerity. Constrained

health budgets are likely to be pressurised by demand for health services and delayed transfers of care that are often attributable to cuts in social care budgets. The different solutions—organizational ones in Scotland and Manchester, and budgetary in Wales—might reward study.

Performance of the four health systems

The UK might provide a superb natural experiment for analysts of politics, but it has not done so well as a natural experiment for analysts of health outcomes. Part of the problem is the curious lack of academic interest in intra-UK comparisons, but part of the problem is also the less curious lack of data on UK health systems performance. Politicians saw little reason to make their data sources and presentation comparable if it would expose them to criticism. As a result, the amount of public, comparable data, never great, is actually diminishing over time.³⁸

This problem of non-comparable data comes atop all the usual problems of comparing health system outcomes, such as the long lag between policies and outcomes (especially in public health), the difficulties of observational studies of policy effectiveness and the near impossibility of experimental ones, uncertainty about how any given policy was actually implemented and the multiple causes at work in society. For example, a bad public health outcome might not cast public health work in a bad light if it would have been even worse without the efforts of the public health system.

Furthermore, there is a problem of baselines. The pernicious effects are visible in debates about Welsh health care, which comparative studies have criticized³⁸ and English Conservatives attacked.^{39,40} There is not much evidence that Welsh health care was ever particularly good. There is now a Welsh government responsible for its quality, but that does not mean the Welsh government created the challenges Wales faces today in areas such as primary care, delayed transfers of care and problematic hospitals. It might only mean that devolution made problems in Wales more visible, created a set of Welsh leaders with the ability and incentive to

address them and gave Welsh voters a way to hold those leaders accountable.

Nonetheless, there are some efforts to compare the performance of the UK's four health systems. The most ambitious efforts were funded by the Nuffield Trust.^{41,42} They found that performance comparisons have been difficult for a variety of reasons but suggested that Welsh healthcare quality is often weaker, and that the English NHS, especially in the North, had an impressive performance in the aptly named 'crude efficiency'. Another series of studies tried to compare the effects of English policy (first targets, then competition) with devolved policies, which consistently de-emphasized competition and were often less forceful in targeting. These studies found improved efficiency and responsiveness to targets in England.^{43,44} However, an international comparison of hospital administrative costs that included England and Scotland found that Scotland had the cheapest healthcare management of all.⁴⁵ The uncertain benefits of managerial innovation have to be weighed against the immediate costs of employing managers.

The OECD's 2016 'Review of Health Care Quality' improved the situation considerably, using a mixture of standard international indicators and some comparable clinical ones to examine quality of the four systems. The OECD had advice for all four systems, but also found that there are no serious and systematic quality differences between them.⁴⁶

There is no simple way to say whether devolved initiatives in areas such as public health or mental health care paid off, though Scotland did reap an immediate benefit in reduced acute myocardial infarction mortality from adopting a ban on smoking in public places sooner than England.^{47,48}

The specific issue of health inequalities, in particular, was the subject of a debate in which Scottish devolved politics played a major part. Scottish leaders had made a commitment to reducing health inequalities, and academics debated whether their, and devolution's, promise of reduced inequalities had been fulfilled.^{49–51} Health inequalities are hard to address everywhere, including in far more egalitarian societies than the UK,⁵² and it has never been apparent that the most effective ways to address

them, such as widespread economic redistribution, are in the hands of any devolved government. Policies in Northern Ireland and Wales unfortunately tend to go unevaluated.

Conclusion

The four UK health systems provide a fascinating and still largely underexplored natural experiment in health policies, with variation in the organization, priorities, funding and management of every aspect of the system. The three devolved systems have independently converged on a simple and integrated administrative model while England continues to develop experimental forms of markets and management. There is an abundance of possible new research topics, but they cannot depend on system-level comparisons with public data because causality is too hard to establish and publicly available comparable data are limited. It is likely that specific analyses of programmes and conditions such as mental health care and cancers will continue to provide the most useful and illuminating data.

The politics and policies of the four systems are also all likely to be shaped by increasing austerity. NHS budgets have been relatively stable since 2010, even if healthcare inflation has made them feel like austerity. Promised deep cuts to English domestic expenditure will feed through to devolved budget envelopes while cuts to UK-wide benefits by the Conservative government might affect health needs. Austerity in local government, which is already impressive, is likely to affect health and health services through cuts to social care, public health in England and non-NHS services to vulnerable populations. The resilience of all UK HSC is already under stress. If the current Conservative UK government sticks to its spending plans, their resilience will be tested as they never have been.

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