

# Devolution and health policy in the UK

---

Scott L Greer

*Summary: The United Kingdom has not one, but four health systems, and they correspond to its four different political systems. Northern Ireland, Scotland, and Wales each have an autonomous legislature that makes health policy while the UK government, somewhat oddly, directly runs England's National Health Service. Each political system has its own party politics and influential policy communities, and they therefore adopt divergent policies in spite of similar baselines and public preferences. Many of their future problems, in fact, might come from the UK's poorly defined rules for organising their interactions.*

*Keywords: England, Scotland, Wales, Northern Ireland, UK, Health Policy*

It was at a private seminar in Edinburgh in 2005, and only after a long day of worthy UK-German comparisons, that a Scottish journalist saw the point that had eluded the speakers. Addressing the Germans just before dinner he said, "I get it. You think that decentralisation is all about doing the same thing, but with slight local modifications. We British think it's about doing different things!"

That journalist was right. The United Kingdom has had four politically autonomous health systems since 1998, with substantial autonomy and developing policy differences. It built them on a legacy of territorial divergence that existed before devolution – Northern Ireland, Scotland, and Wales had slightly different policies administered by their own health departments despite the overall unity of the UK government. The pressure to match such 'administrative devolution' with 'political devolution', i.e. elected governments, came about because of a will to do things differently: a will among Northern Ireland, Scottish, and Welsh political elites to have distinctive health and other policies; a shared will of their leading parties not to

experience the kinds of policies that UK governments elected with English votes imposed on them under the administrations of Margaret Thatcher and John Major; and a shared will among elites in Britain to quarantine themselves from the sectarianism of Northern Ireland's politics.

So eager were the framers of decentralisation – 'devolution' – to safeguard Scottish and Welsh political autonomy, and to quarantine Northern Ireland, that they created an extraordinarily loose settlement for devolution and one that even they now admit was not thought through.<sup>1</sup> The UK, unlike other decentralised and federal countries in Europe, does not have a shared statement of values or quality requirements. England, Scotland or Wales could abolish their National Health Service tomorrow – in fact, the only constraints on doing so would come from EU and European human rights law. The UK does not have shared data requirements or a shared basket of services or any mechanism to produce them. Financing is not just decoupled from any specific services; it is also allocated by the UK government through a formula with no solid legal basis.

At the same time, there are powerful forces creating policy divergence in the UK. First and foremost, each part of the UK has a different political party system. In Scotland and Wales, the Conservatives are a marginal force. The Labour party does

not just contend with the Conservatives in England, who get most of the press; it also must struggle for power and votes with the nationalists of Scotland and Wales. And at the moment those nationalist parties are doing very well; Plaid Cymru the Welsh nationalists are in coalition with Labour, and the Scottish National Party governs Scotland. The English Conservatives are to the right of Labour and never seem quite able to convince the electorate that they really value the NHS model; the SNP and Plaid Cymru are to the left of Labour and accuse it of faithlessness to the NHS.

As a result of these different party politics, health ministers – who are creatures of party politics – make systematically different decisions. They are aided by the fact that the health policy communities of the four systems are very different, with different actors, taboos, social networks and educational backgrounds. Contrast the omnipresent Scottish doctors, Welsh local government, and the English affection for professional (and even North American or Australian) management ideas.

Politicians in the four systems need distinctive ideas, and their policy communities are ready to supply them. There is some highly visible divergence: Scotland provides universal free long-term personal care for older people, Wales does not charge for prescriptions, and England has highly autonomous 'foundation hospitals'.

---

Scott Greer is Assistant Professor of Health Management and Policy, University of Michigan School of Public Health, Ann Arbor, Michigan, USA. Email: slgreer@umich.edu

Some are more nebulous – Wales tried hard to improve public health outcomes.

There are indirect distinctions as well; with four different ministers, four different budgets, and four different organisational structures, the four health systems produce different outcomes measured in hospital stays or patient outcomes (sadly, using four different kinds of data, so comparison is hard).<sup>2,3</sup> Very broadly, the English system relies on introducing ‘contestability’, to force former monopoly health care providers to compete;<sup>4</sup> Scotland has opted for reliance on professionals, less management, and partnership;<sup>5,6</sup> and Wales experimented with local work on the wider determinants of health and on local accountability,<sup>7</sup> although its new government is advancing reorganisation that would eliminate much of the connection of health services with local government. Northern Ireland, where democratic politics fails to provide much accountability for public services, is very stable because politicians are not typically elected on platforms remotely connected with health policy.<sup>8,9</sup>

The loose, but fragile, institutional structure permits this devolution and the different politics provide the energy driving health policy in four different directions. The result is a fragile divergence machine, both capable of creating a remarkable amount of difference in ten years of devolution, but also easy to break because of its weak institutional base.<sup>10</sup> It produces divergence despite the great difficulty analysts have in finding public appetite for divergence: the citizens of all four parts of the UK, when asked, think that social benefits should be the same across the whole state, and support the same (high) levels.<sup>11</sup> But politics, of course, often delivers something different from what citizens want.

### **Fragility of the divergence machine**

Nothing was likely to break the fragile divergence machine in its first nine years because Labour was in office, solely or in coalition, across most of the UK, and its politicians had both the incentives, the internal hierarchies, and the back channels to sort out disputes without them becoming public. The exception was the Northern Ireland Executive, where the local parties intermittently held power but were too immersed in their peace process and too underinvested in health policy expertise to have many opinions. That is different now. The Labour Party is in

trouble in the UK government (where English voters are dominant), is out of office in Scotland, and is in coalition with nationalists in Wales who are unimpressed by both English market experiments and the performance of the existing – Labour-oriented – Welsh health policy establishment.

These changes in party politics revealed weak points of the UK settlement that academics had spelled out before.<sup>12</sup> The set of issues set out below should not surprise those familiar with German, Swiss, or Italian health policy, let alone the situation in fractious Belgium and Spain.

### *Finance*

Northern Ireland, Scotland and Wales receive block grants from the UK government that they can use to spend as they like and have minimal taxing powers. Not only does this reduce their accountability to their citizens (since they do not raise what they spend); it also gives tremendous power to the UK government. This is exacerbated by the peculiar nature of the ‘Barnett formula’ which allocates new spending on a strict per-capita basis without sensitivity to need. This leaves English per-capita spending lower than that of devolved administrations.<sup>13</sup>

### *Quality standards and coverage*

The UK devolution settlement has no shared values, standards, or goals built in. It would be a constitutional challenge to create them. This is unfortunate for Prime Minister Gordon Brown, whose speeches about “Britishness” incessantly invoke “the” NHS (which has never existed in law), along with the BBC, as institutions that justify the continued existence of the UK.

### *Weakly institutionalised intergovernmental relations*

Intergovernmental relations are a blind spot in health policy debates, despite an importance that no sensible analyst of health policy in Spain, Canada, Australia, Germany, or many other countries, would deny. Demographics, diseases, or population characteristics do not matter if the governments cannot arrange the laws, financing, and technical skills to make policy. In the UK, the problem is that the devolution settlement scarcely recognises shared interests, whether in communicable disease control<sup>14</sup> or most other policy areas.<sup>15</sup> Governments are flying blind, relying on weak law and personal connections that are becoming rarer and rarer.

### *EU health policy*

The UK devolution law is clear: the UK government is the member state, not Northern Ireland, Scotland, or Wales, and while it should take their views into account, it need not adopt them.<sup>16</sup> Scotland and Wales have become influential regional governments in the EU partly because they worked so well with the UK, something that depends on a level of friendship that is already eroding.<sup>17</sup> If the UK loses a case against them in the European Court of Justice, the UK pays, but can subsequently claw back the damages from their budgets (and because of that it can intervene to threaten them when they pursue policies it thinks might violate EU law).

### *Public acceptance of divergent policy*

Do the public, as patients or citizens, accept divergence? What parts of the UK’s public accept what level of divergence? And will politicians make a political point of it? The press in each polity tends to present the issue in terms of unfairness measured in spending or services, but there is also a level of unfairness, often inherited from before devolution, in outcomes. Some newspapers (the *Daily Mail*, the *Sun*) have already been using the inflammatory headline ‘Medical Apartheid’ to discuss cases in which devolved health services offer better services than the English NHS because they claim better per-capita funding.

All of these issues could create a political crisis or, more likely, impinge on the devolved governments’ ability to pursue divergent policies. They create incentives for politicians to create crises and blame each other, and leave the UK with few clear mechanisms to resolve disputes.

### **Divergent trajectories?**

Very little public opinion in the UK suggests support for divergent health policies or outcomes (though, as many analysts have pointed out, there has always been a high degree of local variation in the actual performance and even services of the NHS in any part of the UK despite public support for unanimity).<sup>18</sup> So if public opinion polls generally show desire for the same (high) levels of provision, and little support for the idea of divergence in principle, should we expect learning and convergence rather than the divergence predicted by political analysis?

Convergence seems most likely in outcomes that matter greatly to the public, such as waiting or ambulance response

times (where England has hit its low target on elective waits, while targets are easier and less met elsewhere).<sup>19</sup> Welsh voters might be alarmed by their health system, with statistics such as the remarkable 2004 survey finding that only 31% of the Welsh health service leadership said they would want themselves or a loved one to be treated in Wales.<sup>20</sup> It is possible to argue that we have already seen convergence, with limited 'patient choice' schemes across the UK and an emphasis on cutting patient waiting times in Scotland and Wales. In this reading, devolution would mean that Northern Irish, Welsh, and possibly Scottish voters would be able to use the new democratic accountability of their politicians to force standards up. It might even mean that the four governments would adopt each others' successful policy innovations (an argument made most often, in my interviews and experience, by English policymakers).

But the pressures for convergence, or even the pressures for convergence on topics that matter to the public such as waiting times, are often surprisingly weak. Public opinion might suggest a focus on providing the kind of (local, respectful, quality) care that most polls suggest voters want, but many other things shape political agendas, and they generally have more to do with party politics and policy communities than difficult-to-measure and difficult-to-mobilise public preferences.

The reasons to expect a continued level of divergence, on the current coherent trajectories, lie mostly in the strategic situations of political parties. Even if Scotland is now governed by the (minority) government of the nationalist Scottish National Party, the swing voters who decide elections remain much the same in Scotland, and Scottish politics reasonably caters to them. Even if England is currently governed by Labour, the presence of a large Conservative opposition means that the government must cater to Conservative-leaning voters. So those who expected radical change with the devolved elections of 2007 were disappointed; there is a limit to how much even new parties will change policies.

Health system challenges also limit the radicalism of governments. Health services are both easy and hard to change: it is easy for governments to create a blizzard of policies, but it is also very hard to change their underlying nature. English policymakers have had trouble harnessing market dynamics, let alone creating something resembling a market. And that is

despite unprecedented injections of money and political effort.

Welsh efforts to turn the focus of health policy from health care to health have also run into setbacks since most of the policies that improve population health and reduce inequalities are in the hands of other ministers (as with education or transport) or are in the hands of the UK government (as with taxes and benefits). Both English and Welsh health policy has drawn back from the heights of innovation, while the less novel Scottish system, which harkens back to the NHS systems of 1974–1983, is much more politically stable – and that is probably because it is less of a challenge to professional and traditional ways of working in the NHS systems.

So if Scottish, or Welsh, or UK governments of any colour and their oppositions pursue much the same voters and the same distinctive Scottish, Welsh, or English political agendas, we can expect further divergence as day to day policies go in different directions. But as they, together with the parties in the Northern Ireland Executive, are constrained by the fragile system of intergovernmental relations and their various historic legacies, we can also expect that all four of them will continue to find that divergent incremental change is far easier than systemic reform.

---

#### REFERENCES

1. Trench A (ed). *Devolution in Scotland and Wales: Muddled Thinking and Unintended Results, in Unlocking Democracy: Twenty Years of Charter 88, Unlock Democracy*. London: Politics, 2008.
2. Greer SL. *Territorial Politics and Health Policy: UK Health Policy in Comparative Perspective*. Manchester: Manchester University Press, 2004.
3. Greer SL (ed). *The Values of the National Health Services*. London: The Nuffield Trust, 2007.
4. Stevens S. Reform Strategies for the English NHS. *Health Affairs* 2004;23(3):37–44.
5. Woods KJ, Carter D (eds). *Scotland's Health and Health Services*. London: The Stationary Office, 2003.
6. Kerr D, Feeley D. Values in NHS Scotland: a tale of two C-words. In: Greer SL (ed). *Devolving Policy, Diverging Values? The Values of the National Health Services*. London: The Nuffield Trust, 2007.
7. Drakeford M. Health policy in Wales: Making a difference in conditions of difficulty. *Critical Social Policy* 2006;26:543–61.
8. Birrell D. The final outcomes of the review of public administration in Northern Ireland. Tensions and compatibility with devolution, parity and modernisation. *Public Administration* 2008; 86(3):779–93.
9. Wilson R, Wilford R. Northern Ireland: polarisation or normalisation? In: Hazell R (ed). *Constitutional Futures Revisited*. Basingstoke: Palgrave Macmillan, 2008.
10. Greer SL. The fragile divergence machine: citizenship, policy divergence, and intergovernmental relations. In: Trench A (ed). *Devolution and Power in the United Kingdom*. Manchester: Manchester University Press, 2007.
11. Jeffery C. Devolution, public attitudes and social citizenship. In: Greer SL (ed). *Devolution and Social Citizenship in the United Kingdom*. Bristol: Policy, 2009.
12. Trench A (ed). *Devolution and Power in the United Kingdom*. Manchester: Manchester University Press, 2007.
13. Heald D, McLeod A. Beyond Barnett? Financing devolution. In: Adams J, Robinson P (eds). *Devolution in Practice: Public Policy Differences Within the UK*. London: Institute for Public Policy Research, 2002.
14. Rowland D. *Mapping Communicable Disease Control Administration in the UK*. London: Nuffield Trust, 2006.
15. Greer SL, Trench A. *Health and Intergovernmental Relations in the Devolved United Kingdom*. London: The Nuffield Trust, 2008.
16. Greer SL. *Making European Union Health Policy: France, Germany, Spain and the UK*. Buckingham: Open University Press, 2009.
17. Jeffery C, Palmer R. The European Union, devolution, and power. In: Trench A (ed). *Devolution and Power in the United Kingdom*. Manchester: Manchester University Press, 2007.
18. Powell M. How uniform are uniform services? Towards a geography of citizenship. In: Greer SL (ed). *Devolution and Social Citizenship in the United Kingdom*. Bristol: Policy, 2009.
19. Bevan G, Hamblin R. Hitting and missing targets by ambulance services for emergency calls: impacts of different systems of performance measurement within the UK. *Journal of the Royal Statistical Society* 2009;172(1):1–30.
20. Longley M, Beddow T. *NHS Wales Barometer 2004*. Pontypridd: Welsh Institute of Health and Social Care, University of Glamorgan, 2005.