Devolution and divergence in UK health policies

Scott Greer explores how political variation in the UK has led to differences between the health systems of its four nations since devolution.

Devolution and spending will probably be the two main health legacies of Tony Blair’s Labour government. Spending, because the historically low cost NHS received one of the greatest bursts of funding in history, with long term consequences for workforce, infrastructure, and patients; and devolution, because it created four distinct health systems just as that spending started. The politics and policy debates of the four systems are very different, and their leaders have used autonomy to pursue different values with, increasingly, different success.

Autonomy and diversity
Devolution gave the Northern Ireland Assembly, Scottish Parliament, and National Assembly for Wales great power over health services and public health. Under the 1998 legislation they are highly autonomous and not subject to any law of shared standards or values. They receive block grants that are not related to need but can be spent as they choose. Some regard them as overfunded, especially relative to English regions outside London (fig 1); questions arise as to whether their worse statistics with respect to health and other issues (fig 2) justify their higher rates of funding.

The UK political system allows and encourages policy divergence, without much attention to its sustainability or consequences for standards, labour markets, or equity. Divergence has always existed; all four parts of the UK have distinctive histories and influences, but before 1998 they had fundamental political unity. Since then, the distinctive party politics and debates of each jurisdiction have created diverse policies and trajectories.

Scotland: professionalism
Scotland’s trajectory since 1997 has been rooted in the country’s particular politics and medical history. It has also been very coherent, with policy largely proceeding in the direction set out by Labour minister (and surgeon) Sam Galbraith in 1997 and foreshadowed in Scottish implementation before then.

The underlying politics of Scottish health care explain this coherence. Scotland has long had high status medical leaders who are closely connected with policy, and is still home to a dense concentration of professional and academic leaders. They advise a party system in which the main clef is between the Labour Party and Scottish National Party (SNP). Electoral battles tend to be about which party better reflects Scottish distinctiveness and perceived communitarian values; examples of Scottish policies that gained impetus from the chance to lead in the UK include free long term personal care for elderly people and banning smoking in public places.

The result is politics that values professionalism, as well as professionals. The
organisational policies are relatively simple: abolition of the division between purchaser and provider and integration of the entire system into 14 geographical health boards, creating a simple and relatively flat organisational structure. The changes also eliminated the key managerial power base of the trust. Unification of trusts into boards means that Scottish ministers have fewer levers with which to control managers, and managers have fewer levers with which to control their staff. The reliance on professionals appears in the background as an assumption of policy makers and as a consequence of reducing managerial power.

The most serious political problems were connected to something much more tangible: service configurations. Discontent with reconfigurations over recent years led the SNP and Labour to pledge democratic elections for health boards in 2007. This policy is proceeding slowly because the current government does not have a legislative majority and because it is not easy to specify the elected boards’ role and autonomy.

England: markets into managerialism

In England, unlike the other parts of the UK, the main political divisions are between the left and right rather than the left and the further left. This results in more frequent questions about the basic structure and goals of the NHS, and Labour’s approach is geared to demonstrating the service’s value and efficiency to an electorate that might prefer the Conservatives and tax cuts to Labour and the NHS. As a Labour special adviser put it to me in July 2006, an unsatisfactory NHS will make the “middle classes first vote against the NHS with their feet, and then with their votes.” The spending increases and active policy making of the government reflect this perceived urgent need to stabilise the English NHS.

After starting with pragmatism and the partial abolition of the internal market the Blair government began to worry. It substantially increased the use of targets and top-down management, converting the Department of Health into a “department of delivery” with the main objective of meeting targets for waiting times. This reliance on targets might hurt morale; it certainly produced problems with gaming, and it required unsustainably large amounts of political energy. The search for a longer term solution was particularly pressing after 2001 when the government began to increase spending on health. The solution that emerged was “contestability”—the use of competition to frighten NHS managers, professionals, and the expensive UK private sector into greater efficiency. This approach led to policies as diverse as independent sector treatment centres, foundation trusts, patient choice, payment by results, private polyclinics, and regulators spanning NHS and private medicine. All these top-down initiatives were expensive and exhausting. The peak of this trend has therefore probably passed as government finances and power erode.

Wales: limits of localism

Wales was arguably the most radical innovator in health policy. Its objective was to improve public health, best expressed in a plan that—unlike its English and Scottish equivalents—focused on health rather than the NHS and did not confine itself to the Welsh NHS. This objective fitted with the broader profile of Welsh health politics, in which public health and local government advocates were more influential than elsewhere, and in which Labour, facing challenges from the nationalist party Plaid Cymru and its own militants, was inclined to distance itself from London and was strategically rewarded for doing so.

But the overall strategy of localism and a focus on the wider determinants of health did not translate into tactics that ministers could realistically adopt once funding was reallocated to better reflect need. The most obvious policy change was the 2003 reorganisation of NHS Wales. Justified as a way to join up government, the reorganisation left hospital trusts intact but put primary care and commissioning into the hands of 22 local health boards, which were coterminous with (and expected to work closely with) the 22 Welsh local governments. The reorganisation was prolonged and difficult but opened up prospects of better local collaboration in improving public health and reducing inequalities.

The focus on the wider determinants of health fell prey to the lack of appropriate tools. Fundamentally, the determinants of health that were amenable to government action were in other departments (such as education) or in the hands of the UK government (taxes and benefits). So the Welsh public health agenda largely eroded back to campaigns giving lifestyle advice that we see elsewhere. Meanwhile, the reorganisation exacerbated problems in health services. The problems seem to have been about local managerial capacity, the asymmetry between
powerful hospital trusts and fragmented local health boards, and the lack of local government interest in joining up policies.

The coalition government formed between Labour and Plaid Cymru after the 2007 elections committed to abolishing the internal market. The proposals under consultation suggest that the Welsh system will be unified into regional boards, similar to the Scottish model.

**Northern Ireland: permissive managerialism**

Devolution in Northern Ireland has not worked the same as elsewhere, and the problem lies in the politics. Northern Irish politics is not about health or any other public policy; it is about sectarian representation and constitutional argument. For much of its recent history, Northern Ireland politicians have not been able or allowed to make their health policy. Difficulties in the peace process meant that even after devolution, Northern Ireland still saw periods of “direct rule” by ministers of the UK government.

Hence the basic contours of Northern Irish policy making have remained stable. Neither UK ministers nor Northern Irish politicians have much incentive to be interested in health. As a result, change has been slow—for example, general practice fundholding was abolished only in 2003. Managers had freedom to develop their own activities, including some valuable projects, as long as they did not embarrass ministers. This permissive managerialism meant that Northern Ireland health services had operational autonomy but no political support for big decisions—a frustrating situation.

Finally, in 2005-6, the UK government lost patience with the stalled peace process and with the high costs of the Northern Irish public sector and began to make decisions. One of these was to reorganise Northern Ireland’s health and personal social services system into a version of the English system. This action had begun when the restoration of devolution, and the arrival of a new minister, brought it to a halt. Northern Ireland is trapped: the political leadership needed to make great changes is not forthcoming because it brings considerable trouble but no votes.

**A varied NHS**

Health systems are hard to change. As the Welsh and English experiences show, none of the levers available to politicians is truly effective at controlling systems as entrenched, beloved, and complicated as the NHS systems. Both governments set out energetically to change fundamental aspects of the NHS. English policy was to make the service more of a market; Welsh policy was to make it more focused on health and less on sickness. Both strategies disappointed many of their advocates because they did not fit with the legacies of the NHS systems, which do not tolerate the creative destruction of markets and which find it easier to treat the sick than to help the healthy.

As for unity, there has never been a single NHS system in law, and the time to legally establish shared values probably passed with devolution. The four systems are heading in different directions, and in so far as policy affects the work of health systems it is turning them into four different working environments with ever more distinct cultures. If “the NHS” is to continue to exist, it will have to do so as it always has—in the heads and actions of its workers, its patients, and the voters.

Scott L Greer assistant professor of health management and policy, University of Michigan School of Public Health, Ann Arbor, MI 48109-2029, USA slgreer@umich.edu

Accepted: 3 October 2008

Contributors and sources: SLG has studied devolution and health policy since 1997 and has conducted over 300 interviews with doctors, managers, and policy makers across the UK.

Competing interests: None declared.

Provenance and peer review: Commissioned; not externally peer reviewed.


Cite this as: BMJ 2008;337:a2616