Four Way Bet: How devolution has led to four different models for the NHS

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The extent of policy divergence since devolution has surprised many. When the new devolved governments of Northern Ireland, Scotland, and Wales came to life many observers expected that shared histories, legacies, and labour markets would ensure that their health policies remained similar. Others of a more nationalist bent expected little because of their awareness of the limits on the devolved governments. Devolution has defied their expectations. Northern Ireland, Scotland, and Wales proved more than able to make decisions that change life for their populations, and more than willing to -1.1780.94 -27.39 3tions

anybody charged with running a health system faces the problem of how to provide services—and not provide services.

The necessary uncertainty of medical treatment exacerbates these problems. Every patient is unique. Even if illnesses and risk factors are similar, they are numerous and in each person they are reshuffled into a new combination. As a result, it is impossible to construct easy algorithms that would allow mechanisation of most treatment. Neither extracting information, nor diagnosis, nor treatment, nor follow-up is easy enough to be routinised. When it is impossible to routinise a high-stakes activity, Western society habitually hands over the problem to professionals (doctors, nurses, lawyers, clergy, academics). They have undergone training and socialisation that will allow them to make difficult judgements using trained intuition when the ethical issues are serious and there is very little information.

These professionals can look more like a curse than a help to a hard pressed minister or official (or health insurance executive). They are articulate, difficult to control, numerous, and enjoy far more public sympathy than any minister. They are socialised into powerful institutions and organised into powerful lobby groups. The professional organisations might be powerful in politics but still find it hard to accurately represent and control their members. If the British Medical Association or Royal College of Nursing signs up to an agreement, that might not mean that the majority of its members will sign up to it and it certainly might not mean that any changes in the actual professional work will ensue. Efforts to change medical practice from the top down invariably end in struggles for control and authority on individual wards across the country that as often as not are won by professionals jealous of their autonomy and backed up by an authority managers cannot match.

In short, then, every modern Western health service faces a series of linked challenges. They lack the resources to perform all the medicine that might produce health gains. They must construct a system, therefore, that rations. It is easier to construct a system that provides a market, such as a supermarket, than one that can equitably, legitimately, sustainably decide *not* to provide. In the systems committed to some degree of equity and citizenship rights (systems outside the United States), there is an extra tension. If the NHS or Canadian Medicare, or the French health funds take seriously their responsibility to provide equitable outcomes to the whole population, and not just equal access, then they also face a tension between the need to increase access and use among disfavoured populations and the need to limit overall access and use. Outcomes like waiting lists and problematic practice variations, and the budgetary strains or bad headlines that make them problems for decisionmakers, are nothing but the cumulation of millions of small medical decisions about whether to prescribe a medicine, ask for a scan, or send the patient home. In these decisions, health systems necessarily rely on professionals. Only professionals have the skills (or willingness and status) to ration, and only they have the legitimacy to ration where it matters most, namely at the level of the individual patient with a complaint. The result is what Rudolf Klein called “the politics of the double bed” (Klein 1990). Professionals and payers (the state) are stuck

parties and corporatism all raise the political costs of change since they introduce groups (judges, subnational governments, other legislatures) that proponents of a policy *must* pacify in order to make the change. The great strength and greatest weakness of the centralised Westminster system is the ease of policy change. The government can put its business through the legislature, there is limited judicial oversight, and there are few genuinely shared health powers between the UK and devolved bodies. Once a government makes a decision, it is usually able to push it through without much trouble.

Within the three British systems the political costs of change can still vary, but only in extreme situations where party discipline breaks. "Shifting the balance," the 2001–2002 English reorganisation, was very questionable but went through (Department of Health 2001). It had low political costs since it was done with very little parliamentary oversight and the main losers were a group (managers) who were weak due to their unpopularity in the political arena. Foundation hospitals policy, by contrast, has high political costs with major rebellions on key legislative votes. These have been held amidst a storm of backbench-frontbench conflict over universities, justice, Iraq and health, which is what it took to impose significant political costs on the government. Such narrowly won or lost conflicts are far more common in other systems, whether they are seen in the 1-vote margins characteristic of the current U.S. Senate, the tiny Bundesrat (federal upper house) margins by which German policy advances, or the hard-fought intergovernmental conferences by which Canada is changing its federal health policies.

The *organisational costs of change* are the costs in terms of performance that come from a policy change. They amount to the degree of implementation failure that the policy faces, as measured by the amount of actual visible policy failure and as driven by the number of different groups whose non-cooperation can scupper a policy. In systems with shared health powers such as Canada and Australia, governments

The NHS model, therefore, has low political and organisational costs of change. Ministers can, as anybody in the Service will testify, reorganise almost on a whim (and the reasons given for some recent reorganisations have been startlingly trivial). The concentration of power and political authority in the Minister of Health also entails highly concentrated accountability. As long as there is general agreement that there should be public, democratic accountability through a minister for tax-financed services there will be a remarkable degree of public, press, and political concentration on the person of that minister. This means that, in the old phrase of Bevan's, the dropped bedpan anywhere in the system does resonate through the minister's office. It reflects not just the simplifying assumptions of politicians and the public and the politicians' desire for attention; it also reflects a learned and much reinforced public view that the Minister for Health so far outranks other people in the health service that it is not worthwhile to pay attention to anybody else's doings. The result is pressure on the minister to intervene, to set targets, to do something, and the result is yet more centralisation and instability.

Ministerial micromanagement, and efforts to control the uncontrollable, are patently recipes for overall policy and management failure. The result is slowly building pressure for

who can claim to speak for medicine and prognosticate its future, and who are more than able to suggest policies and force issues onto the agenda. Furthermore, the channels between officials and clinical elites that the old Scottish Office opened up in its efforts to govern Scotland remain intact. Before devolution, Scottish Office officials and ministers had to make and implement complex decisions within very tight staffing and research limits. While much of the solution lay in reliance on London, they also maintained tight links with the medical elites of Scotland's Royal Colleges and its mighty university teaching hospitals. These channels remained open after devolution. The introduction of an elected parliament for Scotland did not change the availability of Scottish policy information or its sources; if anything, it made Scotland's insiders more important because Scotland was now averse to using English policies.

England's policy community was formerly the dominant set of thinkers, advocates, and analysts for the UK. Their arguments in London

offered. In turn, this means that learning and emulation will usually not take place between governments. Rather, it will take place through the efforts of policy advocates in each system who are connected into global networks of policy debate. The message of internal markets, which is based on the work of American economist Alain Enthoven, percolated through networks of policy analysts before being taken up by Margaret Thatcher's government as a solution to its problems. New Public Health is driven in large part by the WHO through its meetings, publications, and network of research centres. Policy learning and transfer will take place when academics, policy analysts, and professionals gather for their annual conferences, hear about a development elsewhere, and return home to sell it to their own politicians. If the public health advocates are weak in England, England will not learn much about public health. If the market reformers are weak in Wales, the Welsh policy debatnd will not

MCNs—above all whether funds will eventually be allocated through them, creating budgets organised around conditions such as cancer rather than around organisational units such as hospitals. If that were to happen, it would shift and reduce the ground on which a manager or official could stand and try to control service delivery (although a manager in an organisation aligned with medicine might find life easier and management more effective).

The result is that Scotland's NHS is essentially made up of fifteen large regional boards and increasingly operated by professionals, whether working in managed clinical networks or simply responding to the decrease in managerial control that comes with the slow vitiation of the trusts. Backing up the transition to this professionalist model in organisation, the Scottish NHS is taking quality improvement more seriously than most jurisdictions around the world. It is doing not just with respect for the professions but with leadership from within the professions. Improving medical quality has for decades been a chief campaign of medical elites around the world, and the success of Scotland in establishing quality improvement mechanisms before the rest of the UK is an indicator of their influence in the Scottish policy community. The Scottish Intercollegiate Guidance Network (SIGN) was the most prominent of pre-devolution, voluntary, organisations set up by clinical elites to improve quality, reduce practice variations, and improve medical outcomes. The quality organisations for Scotland identifiably descend from SIGN and its partners. They try to improve medical quality but avoid the regulatory tone of the inspector that suffuses quality improvement agencies in the rest of the UK.

Finally, Scotland takes public health and the wider determinants of health relatively seriously. This is a small irony of a system in which medical elites are dominant. Within medicine, the commanding peaks everywhere are academic medical centres, with their heroic medicine, political visibility, advanced research, huge budgets and outsized traditions and personalities. Medicine has traditionally been organised around them in what Daniel Fox called "hierarchical regionalism" (Fox 1986). For particular historic reasons the leaders of Scottish public health medicine are as strong and well-organised as other medical elites in Scotland and are as entrenched in the universities as any other group. They are able to influence the agenda in favour of attention to public health concerns and population health. The result has been marginal in the overall context of the health services (public health spending is inevitably dwarfed by the cost of health services), but there is a steady drumbeat of interest from ministers in local-area public health initiatives as well as lively debates around issues such as providing free fruit in schools. The 2000 health plan includes many public health interventions (Scottish Executive Health Department 2000).

If Scotland has bet on professionalism to give it good value and extract its politicians from "running" the health services, England has bet on its ability to construct an efficient, properly regulated market-like structure that will rescue the government from responsibility for every detail of health services while providing high-quality, responsive care. English policy combines a variety of measures that have in common the effort to make health services work better by using organisation and techniques borrowed from the private sector.

In organisation, there are three broad and interrelated English policies. These have been visible from before the arrival of Labour and in the 1998 White Paper (Department of Health 1998), but were for some time hidden by an initial rush to demand performance via targets and allocate substantial new funds. They vanished underneath a strong dose of pragmatism; *The NHS Plan* (Department of Health 2000), which makes no mention of most of the policies that dominate government activity, rather demonstrates a line that New Labour used a great deal in its early years, namely "what counts is what works" (Department of Health 1998, for example). Now, policymakers say, the initial drive to clean up the worst quality and efficiency problems is over and the system can be steered onto a new, self-regulating, market-based course and they can move on to priorities such as care for the elderly.

The first aspect of the English reliance on markets is in NHS services organisation. A market, minimally, requires buyers, sellers, and some form of regulation. The English NHS has been reconstituted into such a creature. At the centre are Primary Care Trusts (PCTs), which are responsible for providing population health service either by doing it directly or by contracting

with sellers. The sellers are in other trusts, predominantly acute, mental health, and community trusts that supply services to PCTs. The highest-rated acute trusts are now able to apply to become foundation hospitals, which are not as autonomous as proponents or opponents say but which will not be subject to the same degree of central control; they will rather be driven by the demands of PCTs, patients, and regulators. A large and changing regulatory apparatus is expected to prevent failure, although at the price of prescribing most of what the PCTs can do or buy. At the time of writing this involves the Commission for Health Improvement and the National Institute for Clinical Excellence as well as the Audit Commission and National Audit Office. They are all superimposed on internal medical regulatory bodies such as the General Medical Council (newly supervised by the Commission for the Regulation of Healthcare Professionals) and periodic interventions from outside, whether in the form of police hunting for medical murderers or local councils using their new power to scrutinise the NHS. There are, in total, around 30 organisations in the English NHS that are intended to ensue quality. In theory, these organisations will guarantee good and improving quality, probity, and efficiency while the demands of the market will produce innovation, responsiveness, and local flexibility. In practice, these organisations could well end up controlling most of what PCTs do and only serve to provide an arms-length method to run the service without directly involving the minister in cancer care planning or clinical governance development.

The second thread, of unknown but possibly great importance, is the effort to improve the patient's ability to be a consumer with a degree of choice. This "choice" agenda is based on the view that patients are increasingly consumerist, decreasingly deferential, and increasingly willing to choose a hospital with a shorter waiting time or, in theory, nicer accommodation or a better location. Its main impact is a decision that patients will be, under certain conditions, able to decide where they want their treatment. A computer bookings service will, for example, show different area hospitals and the waiting times for each one so that they patient can decide where to go. Reflecting new European Union jurisprudence, patients can also go abroad for treatment. The real impact of this depends on the extent to which patients take up the ability to choose. One must imagine a patient in a doctor's office, being told that there is a long list for a doctor recommended by the patients' doctor, a short list for somebody unknown, and a shorter list for a person disliked by the doctor sitting in front of the patient. We simply do not know how patients will respond when there is a conflict between the variables such as waiting times that drive the choice agenda and the traditional networks of trust and information medical professionals use to manage uncertainty. If they do take up the choice agenda, then a whole host of new problems emerge, most of them to do with the "inverse care law" (Tudor Hart 1971). This is the rule that the patients who require the most care will get the least—*not*

recruiting, at better rates of pay, from NHS labour; they will only increase the costs to the NHS. English policymakers readily admit that part of their problem must be solved by recruiting professionals in developing countries, but it is open to question how long that can go on given increasing competition for professionals anywhere and charges that it is unethical to recruit in poor countries. This problem does not arise in PFI, which are ubiquitous projects in which the NHS effectively leases a building and

Population health and quality of life is much better guaranteed by reducing binge drinking than by spending more on orthopaedic surgeons. There is an old exculpatory canard that public health improvements necessarily take decades, based on examples such as diet (which has effects decades later). This is not always so, and democratically elected politicians (and good managers) know it. Reducing binge-drinking and violence in town centres at weekends produces desirable effects by Sunday morning. Better integration of health and social services shows in whether or not a discharged patient is back in the hospital a week later after another fall on the same unsecured rug. Both can provide integrated, better, services to vulnerable groups such as the elderly, one parent families, and asylum seekers, and provide new servies in a more coordinated way. The solution often suggested and occasionally tried in the UK is to mend the severed relationship between local government, with its control of social services, and the NHS, with its health services (Northern Ireland, in the 1970s, tried the same; Birrell and Murie 1980). This is exactly what Wales is trying to achieve.

There are two main threads of Welsh health policy. The first, in health services itself, has been an important reorganisation designed to shift the centre of gravity of the health service downward and better integrate local government and social services (National Assembly for Wales 2001b). The essential technique was to make Local Health Boards, the analogues of PCTs, into the chief commissioning bodies of the system, make them coterminous with W
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debates. Elections are largely a contest about who can most vociferously represent two large groups (unionists and nationalists) rather than a policy debate. This tendency of Northern Ireland's sectarian society is exacerbated by decades without real policy debate. One-party Unionist rule under Stormont was not a fertile ground for policy argument, direct rule ministers were largely unconcerned with public policy innovation, and the Belfast Agreement that allowed for devolution was structured to bring parties into government rather than make them govern and therefore riddled the new administration with checks and balances. The policy community that grew up in these decades reflected the essential lack of demand for policy ideas from politicians. What Northern Ireland's governors wanted was stability and functioning services, often amidst a civil war. The policy community that emerged was geared to this need. The resulting health politics was as insider-dominated as Scotland's health politics and for many of the same reasons—a small territorial office had to make major decisions in an information-poor environment and solved its problems by establishing regular contacts with insiders. The insiders, though, were not the already strong, organised, and relatively ideological elites of Scottish medicine but rather the key managers operating the Northern Irish boards and, later, trusts. People arguing in the name of managerial expertise will not propose the same solutions or develop the same radicalism as people with secure positions who are arguing in the name of advancing medical science.

The resulting policy community has two faces. One is, to many frustrated Northern Irish observers, anachronism and immobility. Northern Ireland took years longer than the rest of the UK to establish the internal market (one Northern Irish board was finally ordered to act seriously on Thatcher's health policy agenda—by an incoming Blair government minister) and longer to get rid of it. Acute care allocation has been painfully slow. When a devolved minister (from Sinn Féin, a polarising party even by Northern Irish standards) tried to make a decision about Belfast maternity services it was roundly criticised and subject to judicial review. Faced with a real set of social costs and benefits in the next major decision, the location of a hospital for Tyrone and Fermanagh, she preferred to stall rather than cope with the problems of making policy for a party whose appeal has very little to do with delivering health services. Suspension at least gave relief from that little 4dv2 TD0.0272 Tced andn—o.0238 Tw(Faced0.02 Faced0.0272p3ion idd8hb.n t0..amW9la.eoctung health

the constraints of available resources? Since 1983, the answer in the UK and most of the world has been the imposition of professional management. Since 1989, the answer has further been the introduction of market discipline (again, most advanced industrial countries moved alongside the UK). The skills of managers and the fire of competition were to produce efficient outcomes. The extent to which anything like a market appeared, or to which these dynamics worked, can be discussed. But Scotland is going one better and slowly moving to a different model based on using professions rather than managing professions.

The logic behind the Scottish trajectory is that managers, the chosen instrument of policy elsewhere, are unlikely to understand medical work processes in enough detail to allocate resources adequately and that only the professionals have the legitimacy to make the rationing decisions that any system must have made. Managed Clinical Networks are a far cry from the professional-dominated system that was the UK under consensus management, but they are part of an overall rollback first of markets, then of the autonomous trusts that made up a market, and now of management itself.

This could have two signal advantages if it works. The first is that it will use the professionals rather than try to work against them. There is considerable evidence er consen-0.0416 TwD-0027[side the UK). 1891 5s hm[4rr -08.95 m
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able to fill in for weak internal policy capacity (and, incidentally, further raise the profile of their issues on the agenda). In Wales, the groups that weighed heavily in the new health politics were from local government and public health, and had little existing capacity to organise health services. It is one thing to know a population's problems and needs, which a good local councillor will, and another thing to be able to relate them to the complex business of commissioning and providing health services. Local government representatives, meanwhile, often find that service on an LHB is "no fun," particularly when "the first thing you have to do is address an eight million pound deficit." This further reduces the likelihood that LHB service will attract the most capable local government representatives. The result is that the centre and the unified public health corps provide key expertise, thereby vitiating much of the LHB role, and are easily able to overawe any other units in the system. Big trusts, meanwhile, are often able to ignore weak LHBs.

The lesson from Wales, then, is that lack of capacity can undo the best-intentioned reforms. There are a few areas where the local government, LHB, and National Assembly are in tune and working well, but more where there have been problems that inexorably draw power back up to Cardiff. It will be some time before the civil service, managerial corps, professionals, and politicians of Wales have the collective expertise to replace 5 appointed authorities with 22 locally accountable units. By then the system might well have congealed into a highly centralised health service with a great deal of local bureaucracy—or been reorganised again. That would be a sad outcome. It should, at least, carry the lesson that capacity-building is vital and difficult. Efforts to integrate local government, for example, should be planned carefully in order to respond to the fact that local councillors will arrive with few or no health planning skills. Reorganisers should remember to first count the number of officials they have who are capable of enumerating the functions of a given tier of organisation, let alone reallocating them or setting up the new services. Otherwise, the best of ideas might perish in the execution.

The different strategies pursued by the four UK health systems are not just efforts to get as much value as possible out of health investment. They are also efforts to, in the words of one advisor, "remove the hardwiring" between service delivery and the minister. Scotland is trying to reinstate professionals as the line of defence, England is trying to create satisfying market-like mechanisms to deliver at arms

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rebound on them negatively. A second is to introduce countervailing powers within the system who are able to raise the organisational costs of change. Local government in Wales and professional networks in Scotland both have potential to become powerful actors that can veto the proposals of the hyperactive centre. Just as corporatist funds in Germany deprive the German federal state of levers with which to intervene in medical decisionmaking, the LHBs or MCNs might establish an important enough role in delivery to be able to resist or debate central decisions. What is sure, however, is that central imposition of one more new localism is unlikely to work.

Harrison, S., and R. Schulz. 1989. Clinical Autonomy in the United Kingdom and the United States: Contrasts and Convergence. In *Controlling Medical Professionals: The Comparative Politics of Health Governance*, ed. G. Freddi and J. W. Björkman, 198–209. London: Sage.

Klein, R. 1990. The state and the profession: The politics of the double bed. *British Medical Journal* 301 (3 October):700–702.

Powell, J. E. 1966. *A new look at medicine and politics.* London: Pitman Medical.

Schulz, R., and S. Harrison. 1984. Consensus Management in the British National Health Service: Implications for the United States. *Milbank Quarterly* 62:657–81.

Tudor Hart, Julian. 1971. The Inverse Care Law. *The Lancet,* 27 February.

Department of Health. 1998. *The New NHS: Modern-Dependable.* London: HMSO.

—. 2000. *For the Benefit of Patients: A concordat with the Private and Voluntary Health Care Provider Sector.* London: Department of Health.

—. 2000. *The NHS Plan: A plan for investment, a plan for reform.* London: Department of Health.

—. 2001. *Shifting the Balance within the NHS: Securing Delivery.* London: Department of Health.

—. 2002. *Getting Ahead of the Curve: A strategy for combating infectious diseases (including other aspects of health protection).* London: HMSO.

National Assembly for Wales. 2001a. *Improving Health in Wales: A Plan for the NHS with its Partners.* Cardiff: National Assembly for Wales.

—. 2001b. *Structural Change in the NHS in Wales.* Cardiff: National Assembly for Wales.

Review of Health and Social Care in Wales. 2003. *The Review of Health and Social Care in Wales: The Report of the Project Team Advised by Derek Wanless.* Cardiff: National Assembly for Wales.

Scottish Executive Health Department. 2000. *Our National Health: A Plan for Action, a Plan for Change.* Edinburgh: HMSO.

—. 2003. *Partnership for Care: Scotland's Health White Paper.* Edinburgh: HMSO.

Scottish Office. 1997. *Designed to Care: Renewing the National Health Service in Scotland.* Edinburgh: HMSO.

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