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

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Contents

Key Points

The four UK health systems face common challenges. Like all health systems, they must ration resources in life and death situations and they must rely on articulate, popular, unmanageable professionals to do it. Like other state-owned systems, they must also cope with the close contact between the political system and the health services. This means that they must get value from taxes, keep professionals on side, ration legitimately, and somehow disengage their politicians from management of and accountability for the frontline services.

Each system has since devolution developed a different model:

- Scotland has bet on *professionalism* in which it tries to align organisation with the existing structure of medicine. This means reducing layers of management and replacing them with clinical networks, increasing the role of professionals in rationing and resource allocation.
- England has bet on *markets* in which independent trusts, similar to private firms, will contract with each other for care while approximately thirty regulatory organisations will ensure quality. Competition, management, and regulation will be the keys to getting value from health spending while severing the link between frontline health services and the Minister.
- Wales has bet on *localism*. This means integrating health and local government in order to coordinate care and focus on determinants of health rather than treating the sick. It tries to use localism as the lever to make the NHS into a national Health service rather than a national Sickness service.
- Northern Ireland, in and out of devolution, has continued to bet on *permissive managerialism*. This is a system that focuses on keeping services going in tough conditions and otherwise produces little overall policy and enforces less. It provides stability in difficult conditions—at the cost of no policy and with the benefit of local experimentation and variation.

Four lessons stand out from the different systems:

- *Pay attention to who gives advice, and give advice.* These bets are not accidents; they reflect the influence of policy advocates in each system who persistently raise questions and supply answers. Policy change will come about if and when others join the conversation with their own problems and policy ideas.
- *Professionals can be your friends*. For two decades the UK has tried to use professional management and private-sector models to deliver health services and health services rationing. This has led to endemic conflict between government and professionals. Scotland's model is the most radical, for it instead tries to align organisation with professional models and thereby use, rather than attack, the professionals' role in rationing and treatment. It is radical because it starts with the way health services actually work.
- *Capacity matters.* Wales tried to create the most localist UK system and produced a highly centralised one. It shows us what can happen when a policy is more complicated than the system can implement, and how easy it is to pick such a policy without realising it.
- *Disengagement is hard*. All four governments are trying to disengage from frontline services. But the degree of determined central intervention required to reorganise a system into its new, self-governing mode is so great as to leave the system more centralised than before. Countervailing powers must be included, since yet another centrally imposed new localism will never work.

I. Introduction: Global Problems and Local Solutions

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 do so.

Why did such divergence come about? What can we learn from it about the solution to problems present in every health system around the world—problems of local variation, cost containment, quality improvement, and the bases of population health? The United Kingdom has decided to make itself an experiment in health policy and management. We can rightfully ask why it has done so and what we can learn about global health problems.

This paper supplies some of the answers. It is based on the findings from the Constitution Unit's four-year multimethod Devolution and Health study, funded by the Nuffield Trust and the Leverhulme Trust. It is based on over 100 semistructured interviews, participant observation in meetings, press and government document monitoring and a survey of health elites around the United Kingdom. A list of publications from the project, which present and discuss the arguments and evidence in more detail, is appended.

The second part of the paper discusses the basic challenges that define the NHS systems across the UK and the similar tools they have to respond. Essentially, they face problems of uncertainty and rationing that are solved by the inclusion of professionals, who then pose their own problems for political masters.

The third part presents a short explanation of why the four component parts of the UK choose policies as they do. The key differences between their policies matches the differences in their policy communities. The insiders in health policy in England, Northern Ireland, Scotland, and Wales, are different people with different goals and arguments. They shape the agenda, filter the questions asked and supply the contending answers. Their influence over decisions explains how the myriad decisions made by each governments cumulate into distinct trajectories of health policy.

The fourth part analyses the policy trajectories. Each system has placed a bet on a different logic of health service governance. Faced with common problems of rationing and provision and political imperatives to get value for tax money, the four countries have placed their bets on different parts of the system. England has bet on market, Scotland has bet on professionalism, Wales has bet on localism, and Northern Ireland has bet on permissive managerialism.

The concluding fifth part draws some lessons from the text that should be useful—both for what they tell us about the politics of health in the UK, and for what they tell us about the virtues and failings of each of the different models. The United Kingdom is a laboratory for different types of health service management and provision, and this section tries to distil some basic lessons about the politics of health provision in the UK.

II. Common Challenges

The four health systems of England, Northern Ireland, Scotland, and Wales face problems shared by all health systems, by all public health systems, and by all NHS-model public health systems.

A. Global agendas

Any health system is built around the need to provide services in a context of deep uncertainty and essentially unlimited demand. Whether it is a fee-for-service insurer in the United States or the Swedish health service, the payer must balance the obligation to provide health despite the fact that the procedures and services that provide health could easily outpace the resources available. A sustainable system, therefore, must also be built around the need to ration services. There never seems to be an easy way to bridge the gap between the potential amount of extra treatment and tests that could be desirable and the actual funds that the NHS can extract from the taxpayer or the American Health Maintenance Organization (HMO) can squeeze out of a big employer's health insurance fund. As a result,

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 with each other, no matter how they might quarrel, since the state pays them but the professionals are the only group who can provide the health care the state wants and the only group that can provide the rationing that the state needs.

B. NHS issues

The NHS is the modal for a subcategory of universal, public health services. The national health service model is a health service in which almost all care is funded out of general taxation and directly provided by public bodies that employ or are prime contractors with professionals. The defining characteristics of an NHS-model system are the low organisational costs and low political costs of change compared to other health systems. It is not easy to change health policy, but it is easier to do so in the UK than elsewhere. In NHS systems, therefore, the minister is much more engaged than his or her counterparts in other countries.

The *political costs of change* are the costs to a politician associated with getting a policy into law. They are roughly equal to the number of opportunities opponents have to stop a policy, and they are low in the UK's Westminster systems (including Scotland and Wales). Federalism with shared competencies, separation of powers, judicial review, weak

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 willingly sign agreements that they do not deliver. The Canadian federal government's organisational costs of change are driven up by its reliance on provinces to deliver any health services. The provinces' costs of change are driven up by their reliance on a substantial amount of federal funding and the constraint it brings. Both accuse each other of bad faith. Australian governments' costs of policy change are driven up by blame and cost-shifting between Commonwealth (federal) and state parts of the health system. Sweden uses its powerful local governments to separate the central government from delivery decisions but thereby incurs the higher organisational costs of inducing elected local governments to change policy because the central government wants them to. In the few areas where UK local government is allowed to matter, its ability to frustrate or reinterpret central government policy in line with its independent electoral mandate is impressive.

In systems with genuine corporatism (not the voluntaristic partnerships of British past), the government might be only a member of labour-management boards or reduced (as in Germany) to setting the legal framework rather than actually making decisions. The German federal state regulates rather than runs its health insurance, and therefore has few real levers with which to influence health service organisation or delivery. Finally, contracts also raise the organisational costs of change relative to direct employment relations. If the German government can induce funds to make the decisions that it seeks, the funds then still need to extract the outcome from the doctors they pay. As a result, the organisational costs of change in Germany or similar social insurance systems are relatively high.

Again, the NHS model systems face lower organisational costs of change than systems in other parts of the world. In each part of the UK one government owns and pays for most of the health system. There are no fixed countervailing powers within the system. No UK government relies on any other government to deliver or fund health services on its territory. There are no unions or employers organisations necessarily involved in health decisionmaking. They are pressure groups that can be strong but still can be brushed aside. Local government might have representation or rights with regards to health services but is not vital to policy change. Subordinate units of the NHS are weak. It need not be so, and semi-forgotten organisations such as the English regional boards were more able to resist central pressure, but today there are few managers or board members who think they exist other than at the minister's pleasure.

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 disengagement—for a form of health services that will free the minister from the clatter of the dropped bedpan and free the health services from the uncountable targets sent down from the centre (at one minister's last count, over 450 in England). The question is not just whether disengagement will work if the press continues to put the minister on the front page every time there is a crisis. The question is also how the system will be rebuilt to allow disengagement, and with what costs and benefits.

III. Why they choose as they do

In politics as in medicine treatment might be difficult and questionable but diagnosis is yet more difficult and yet more questionable. The solution that politicians and patients alike will use is to call in a professional. The patient will see a doctor and the politician will see some combination of academics, insiders, officials, and special advisers legitimated as the people who understand the systems, their needs, and their capabilities.

The difficulty at the interface between politics and the health systems is that politicians are never asked a clear "right" question or supplied with a clear "right" answer. A new minister for health will immediately be besieged by advocates of individual diseases, private finance initiatives (PFI), health improvement, trust mergers, mental health, particular hospitals, particular treatments, particular professions, restrictions on foreigners' use of facilities, outpatient surgery, greater use of pharmacists, American management techniques, patient choice, localism, and better hospital food. The only thing that is clear is that not all of these issues will get equal attention, especially as soon as a crisis erupts. The ones that seem to offer the most potential useful action and greatest visibility will win out.

As a consequence, the causes with the most articulate, widespread, and persistent advocates will get most of the attention. Advocates of greater use of the private sector are largely confined to England, and it is in England that PFI and conflict its use over are greatest. Advocates of managed clinical networks are most present in Scotland, Scottish conferences are most likely to hear evangelical discussions of their virtues, and Scotland is where policy bets on managed clinical networks. In other words, the people who cluster around a health department offering skills, advice, opinions, and filtering others' opinions will over time ask most of the questions and supply most of the answers. These groups, called policy communities, set the agenda over time.

These policy communities vary across the UK. The kinds of people who can and do make claims to speak for, interpret, and change the Scottish health system are not the kinds of people who can make such claims about the English, Northern Irish, or Welsh health systems.

Scotland's inherited policy community is dominated by policy insiders in close touch with its well-organised, high-status, impressive elite medical infrastructure. The four "ancient" universities and their high-status professionals influence the agenda, pushing issues such as clinical governance up the agenda long before the rest of the UK and now proposing solutions based on professionals' view of where medicine is going. The Scottish health policy landscape is therefore densely populated with groups based in very high-status, important medical institutions who are willing and able to participate in policy,

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 set the UK agenda, and insiders in Belfast, Cardiff, or Edinburgh were reduced to mostly marginal changes in policy and implementation. Now, with devolution, we can see the extent to which English policy agendas and decisions differ from those of the rest of the UK. Above all, England differs in the strength of managerialist thinking and market-based solutions. Unlike any other part of the UK, England has an important Conservative party. Unlike any other part of the UK, England has a network of pro-market think tanks and policy advocates and a large infrastructure of academic specialists and consultants who focus on using and extending markets. Unlike any other part of the UK, there is real debate about whether to preserve the NHS in its current form. And unlike the rest of the UK, the theory and practice of New Public Management, which focuses on the use of market mechanisms to extract value and prevent overprovision, has settled in the Whitehall departments. As a result, English health policy is almost uniformly conducted on the assumption that the health service will be run by management and organised into autonomous units (trusts) with contractual relationships between them. Market reformers dominate England's policy community.

Wales demonstrates that politics abhors a vacuum. Neither clinical elites nor market reformers are strong in Wales, and the small number of medical elites have traditionally been oriented towards England rather than Welsh policy and politics. The Royal Colleges have weak Welsh organisation (and are often seen in Wales as being London-centric), there are few large-scale medical centres, and big teaching hospitals do not loom so large as in Scotland. Wales has a relatively small academic policy analysis infrastructure and its think tanks are both small and relatively left-wing. As a result, traditional "outsiders" in health policy play a much more important role in Welsh diagnosis and treatment. Local government, hopelessly marginal in health policy elsewhere, plays a real role in Welsh health policy debates, unions have influence on issues beyond the defense of their members' pay and rights, and public health, weak elsewhere, has played a meaningful role in setting the agenda.

Northern Ireland, like Scotland, is dominated by its insiders and, like Scotland, has most of the same insiders as before 1998. There is no strong infrastructure of academic policy advocates as there is in England, Royal Colleges are weak, there are few think tanks, and few policy advocates are trying to break into the policy community. The difference between the insider systems lies in what it takes to be an insider in Northern Ireland versus Scotland. Scotland's strong, organised, high-status medical elites long ago staked out a claim to speak for the system from a position of knowledge, legitimacy, and superior ability to foresee developments in medicine. With such medical elites come a serious agenda focusing on issues such as quality and clinical networks. By contrast, Northern Ireland's insiders are those who are necessary to keep the system running—mostly a mixture of managers from various organisations and civil servants. Their influence reflects not just Northern Ireland's small size but also its easygoing culture, inherited from direct rule (when British ministers were otherwise occupied) and, before that, the conservative, effectively one-party Stormont regime. These decades produced an ingrained disrespect for local politicians and a health policy community built around those who could keep the system running. In Northern Ireland that meant managers rather than the determined advocates of Scotland's policy community.

Each policy community will ensure that different questions get asked and different answers

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 community will not learn much about new developments in market-based managed care. There is a global menu, but each country will order different items.

IV. What they choose

The four systems each have their own distinct trajectory discernable amidst their many small decisions on topics such as organisational charts, investment in new public health, clinical governance regimes, and the use of the private sector. Each has a guiding theme: professionalism for Scotland, markets for England, localism for Wales and permissive managerialism for Northern Ireland.

A. Scotland: Professionalism

Scotland's health politics are increasingly built around the professional structure of medicine rather than around the use of management. Reflecting the strength and policy skills of its medical elites, Scottish policy builds on their analyses of how medicine does and will work. This entails greater reliance on professionals, efforts to align formal structures with professional ways of working, decreased reliance on managers to operate the system, a focus on quality improvement led from within the professions, and the elimination of the quasi-autonomous units (trusts) that form one of Thatcher's most important legacies and the building blocks of any contract-based system.

In 1997, when the incoming Labour government delivered the first separate English, Scottish, and Welsh health White Papers, the Scottish paper visibly rolled back the internal market and placed more emphasis on partnership (Scottish Office 1997). In particular contrast to the others, Scotland's white paper had only the weakest gestures in the direction of establishing primary care-based purchasing and de-emphasised commissioning. Instead of being more or less autonomous market participants, trusts were to be administratively autonomous. Policy would be the task of the large regional health boards.

Abolishing trusts is a daunting financial and legislative challenge that no government would be eager to take. This difficulty gave Scotland's trusts a short reprieve from the consequences of their unpopularity with professionals and Scottish Labour. In the Scottish health plan of 2000 (Scottish Executive Health Department 2000) they remained but policies shifted towards their integration into the boards (even including rebranding all the units in a board area as the same thing: NHS Greater Glasgow or NHS Forth Valley replaced the multiplicity of organisations). These fifteen boards increasingly came to be the key management units for the whole of the Scottish health service. Finally a 2003 White Paper (Scottish Executive Health Department 2003) announced the abolition of the trusts.

Such changes, at face value, look like a simple centralisation of the system and reduction in the autonomy of the component units. Where there had been multiple trusts, primary care organisations and boards, now there will be fifteen boards and their subunits. It is not, however just a recentralisation of management. It is also a reduction in the role of management. Scottish health policy, reflecting the ability of its medical elites to formulate cogent policy proposals, is increasingly based on aligning the formal structure of health policy with the structure of the professions. The most striking (if difficult to implement) aspect of this is the new reliance on Managed Clinical Networks (MCNs), which the 2003 White Paper proposes as a chief mechanism for resource allocation and service delivery. Managed Clinical Networks are groups of professionals across a wide area who work on a similar problem (the most advanced MCNs are in cancer care) and pool resources in order to best allocate and use them. There is at the time of writing considerable debate within Scottish health policy as to what may be the position of the

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).

B. England: Markets

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* because of failure to provide facilities but because using the health care system requires organisational literacy that the sickest and worst-off usually lack. Choice potentially exacerbates this dynamic—will the worst-off really receive and take up the opportunity to have elective surgery in Lille?

The third thread, confused and hotly debated, is the direct import of the private sector to enhance capacity and improve management (or at least stimulate it to do better). The "diversity" agenda is of a piece with New Labour thought (and ingrained English affection for New Public Management) that argues the ends, not the means, are what matter. If the government's goal is to provide high-quality primary care at a good price, there is no principled reason why it should not be provided by Boots the Chemists rather than by a traditional GP, and there is no reason why capacity increases should be through traditional capital investment rather than contracting private-sector, or French, facilities. This includes efforts to stimulate NHS management; after a (hotly contested) *BMJ* article suggesting that California HMO Kaiser Permanente is better value than the NHS, American HMO managers were brought in to run a few small parts of the English NHS (Feachem, Sekhri, and White 2002). It includes "fast-track" treatment centres where (foreign, as it turns out) providers do simple surgery on an industrial scale in order to clear waiting lists. The English private sector has not done especially well out of this, but there is a Concordat with them in which the government promises to work with them to solve government problems (Department of Health 2000). There are a number of basic questions that are not answered by this argument, above all what impact it will have on staffing shortages. New entrants will not be much help if the additional providers are

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 some services from the private sector (the building might or might not be transferred to the NHS after the duration of the contract, which is generally around the end of its useful life). England has embraced PFI in a way no other part of the UK has done and been able to develop a PFI sector in a way that smaller Northern Ireland, Scotland, and Wales cannot.

The shift to commissioning, choice, and diversity are more than enough to keep any manager, minister, or official fully occupied. It certainly has had that effect on public health, which despite high hopes has found itself almost as marginal under the Labour government as under the Conservatives. The simplest indicator is organisational form. Scottish public health officers are in the same jobs, and strong in the increasingly powerful boards. Welsh public health officers are in a unified, Wales-wide corps and central to government plans. England's public health teams are partly in Government Offices for the regions, partly in PCTs (where public health is effectively an optional extra) and partly in a series of quangos that are being reorganised around health protection issues rather than health promotion (Department of Health 2002). Quality, in stark contrast to Scotland, is a regulatory function that might be friendly and helpful but is nevertheless regulatory rather than carried out from within the professions. The various organisations are there to make sure that the pseudo-market produces the desired outcomes rather than to help the professions fulfill their ambitions. This regulatory tone has become increasingly marked and it is not an accident that the new agency (created to merge several of the regulators and due to start work in April 2004) does not have an optimistic name such as its predecessor the Commission for Health Improvement. Rather, it is named the Commission for Healthcare Audit and Inspection. That is a regulatory agency rather than a helping hand, and it must be so if a market is genuinely at work.

C. Wales: Localism

Scotland and England have taken opposing sides in an old and well-entrenched NHS debate between managers and professionals. England opted for managers and markets, reflecting the prominence of their advocates and arguments in the English policy community. Scotland, reflecting its weaker market reformers and its proportionately stronger medical institutions, opted for professionalism. The Welsh policy community has neither of these traditionally dominant groups in the same strength as in England or Scotland, and has accordingly offered opportunities to groups that are typically excluded. The result has been a health policy with real input from public health and local government and which reflects their shared interest in the development of local solutions to problems of population health. Wales has placed its bet on localism.

The localist logic is well-known but rarely implemented. Its essential argument is based on two uncontroversial statements. The first is that the health services are often provided in quantities and ways that do not reflect or involve the local community. There are few channels by which the local community could be brought into an essentially technocratic health policy community, and the result is a missed opportunity for local involvement that might lead to better planning and joint working. The second is that the NHS as it exists is misnamed. The NHS, for all practical purposes, is a National Sickness Service that treats people once they are ill. This is expensive and unpleasant. It would be cheaper and more agreeable to reduce the causes of ill health and thereby improve the population's quality of life, the economy (which is hurt by sick days and large populations incapable of working), and the budget of the health service itself. Even a small increase in good diet or exercise, or a small reduction in binge drinking and smoking, could feed through into a great deal less money spent on surgery, oncology, and traumatology. The problem is how to make such changes in population behaviour.

The promise of local joint working for population health promises to kill two birds with one stone. Moving responsibility for key parts of the health system to the local level promises to both increase local participation and integration and shift the emphasis of the health services away from service provision towards population health.

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 Wales' 22 local government areas, and create both local government representation on the boards and an obligation to the LHBs and local authorities to work together. The Welsh coalition agreement (the Partnership Agreement, 2000) had specifically promised a period of stability, but this was rapidly abandoned in order to make these changes and the new structure began operation on 1 April 2003. The goal of the new design is to make sure that health services reflect local needs rather than inherited patterns of funding or the desires of elites. Furthermore to put traditional health services into a pot of money controlled at the local level might reduce their inbuilt advantage and allow the LHBs to spend less on hospitals and more on population health. It is worth noting that this is a commissioning-based system; in theory, England and Wales could still swap logics since they both have the same basic architecture of locally based commissioners and trusts. It is also worth noting that in a small country such as Wales, if the LHBs do not prove expert and determined enough to counterbalance the centre, the centre could easily take over yet more of the system.

The second thread is increased investment in and regard for the public health function overall. The Welsh health plan of 2000 was a strikingly original document that focused on health rather than the provision of health services and treated the NHS Wales as one more tool available to add quality and length to life, alongside education, police, transport, and economic development (National Assembly for Wales 2001a). Inequalities reduction and social inclusion have both received substantial budget increases, while the public health corps in Wales (previously housed in the Health Authorities) is now unified and in a key position to influence policy in a fragmented, information-poor system. The National Assembly is making serious efforts to promote the public health function and local joint working, with increased funds and attention from ministers.

This agenda, based on local control and local joint working, has its costs and benefits. Potential benefits include improved work on social inclusion and better treatment of groups such as the elderly, mentally ill, and children who tend to fall through the gaps between the health services and social services. Immediate costs are more visible, both in the chaos of reorganisation and in the attention distracted from operating health services and in the lack of attention given to running acute services. The costs, at least, have started to show. To some extent, the Welsh health policy agenda has already moved from the localist agenda to the problems of the acute services sector, crystallised by a Review advised by Derek Wanless (Review of Health and Social Care in Wales 2003)

D. Northern Ireland: Permissive managerialism

Northern Ireland differs from the three British systems in that it is not always self-governing, not necessarily capable of self-government, and not well structured to produce government when it is self-governing. The essential problem of Northern Irish politics is that the gravitational pull of constitutional and sectarian politics overpowers anything else, including policy

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 problem—a direct rule minister put the new hospital in Fermanagh. Larger policy issues such as reorganisation escaped completely. The result is that on any given agenda item—organisation, public health, quality, or the use of the private sector—Northern Ireland has simply not moved much or at all. There is little pressure from within a stability-oriented policy community and almost none at all from politicians preoccupied with the fate of nations and unschooled in policymaking.

The other face is less visible. Northern Irish institutions have more room to diverge from each other because they and their leadership are subjected to less top-down pressure than in other systems. The result is that the internal operations of the different organisations can vary a great deal, as can their priorities. Some parts of the Northern Irish health service have a real focus on working with their communities in the interests of improving wider determinants of health, some have a kind of pastoral ethos, others have much better service integration between theoretically separate (competing!) units, and others are aggressive acute centres. Some coast or slowly decline. So long as services continue to be delivered with a minimum of fuss, chief executives and boards have greater latitude to invest in public health or service integration than their colleagues in Great Britain. There was a brief exception under devolution, when the Department, run like all the others by politicians unused to policy work, became involved in extremely detailed questions, going so far as to annually allocate new electric wheelchairs to different trusts. The likely effect of such centralism, given the lack of an overall policy agenda, would probably be to stifle valuable local efforts without improving the performance of the system overall.

Northern Ireland, then, has placed no great new bets in the manner of England, Scotland, and Wales. Rather, it has persisted with what is perforce incremental change. It is not difficult to find critics of this politics. It is offensive to believers in democratic self-government (although not necessarily to the many who do not believe in the existence of Northern Ireland). Perhaps it is storing up trouble. Northern Ireland is passing up opportunities, which is not good. Perhaps, worse, it is thereby becoming a dangerous anachronism. It has difficulty

connecting with its population. Nineteen trusts and four boards are seen by most of the public as too many quangos to be involved in running the health service.

It is also unlikely to change. Even with devolution, it lacked a coherent ideology dominant within its policy community. Scottish medical elites, English market reformers, and Welsh localists all bring with them a coherent worldview and set of issues they want addressed in particular ways. There is no such group in Northern Ireland with a pre-established worldview and useful resources such as information and ideas. Rather, the people with information and channels with the ministers were chosen as experts in running a stable system. Many of them go on to develop worthwhile activities, but that its as much a feature of permissive managerialism as slow policy change. It is, at least, why Northern Irish stability is not necessarily as great a problem as often made out to be. If local variation, organisational stability, and coherent identities are worth having, and all three British systems seem to think so, then Northern Ireland's situation is not all bad.

V. Conclusion

The first and clearest lesson is that any policy has its downside. Each UK system has opted for certain priorities and pays the price in other areas. England has focused on regulation and markets to squeeze efficiency and customer satisfaction out of its health service. The price is a lack of interest in the determinants of health and a hostile relationship with many professionals. Scotland has opted for professionalism, which in its particular case also includes some attention to public health, but by returning the health service to professional leaders it has given up levers with which to better integrate it into local communities or manage it to a politically determined end. Wales has opted for localism and the wider determinants of health, at the price of severe capacity problems and inattention to what some see as a crisis in hospital services. Northern Ireland has opted for stability, which allows for local experimentation but prevents major changes and maintains the gulf between Northern Irish public services and the populations they serve.

In addition to the costs and benefits visible in each system, there are more lessons to be found in the politics of devolved health. Four lessons deserve special attention.

A. Pay attention to who gives advice…and give advice!

Partisan politics, confusion, and mistakes matter as much in health as in any other area of politics. But there are systematic regularities in the decisions each country makes over time, and these go beyond particular partisan constellations or need of a given minister to make a mark in the job. The arguments in politics take place around an agenda, and that agenda is strongly influenced by the people who give the advice and have command of knowledge, arguments, and the ability to speak on behalf of the people who work in the system. If we want to understand where a system is, or is going, it pays to look closely at the policy communities.

If one wants to change rather than understand, then participating in policy debates can have real effects. By persistently raising questions and suggesting answers, policy advocates in and around the different UK health systems have had an impact on the direction and emphases of policy. There are large areas of the health services with no strong tradition of articulating arguments and participating in policy. Mobilising their knowledge and interests can work. The experience of Wales shows how "outsiders" can move to the centre of policy debate. The experience of Scotland shows how professionals can play a real role in shaping a health system. Even if participation gives no satisfaction in individual decisions, the stronger and more persistent the advocates, the more likely they will influence the little decisions that eventually cumulate into national trajectories.

B. Professionals can be your friends

Scotland is enacting the single most interesting experiment in the UK (if it is properly implemented) since it is removing first the building-blocks of the inherited NHS (trusts) and eroding the bedrock of the four systems (management). The logic behind this is fascinating and contains a potentially explosive lesson about what makes health services work. If the essential problem of the health services is their obligation to ration and to provide, then the form of rationing is crucial. How does a system strike the balance between providing and not providing in a way that is just and yet falls within

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 from the days of consensus management that professionals, given fixed budgets and autonomy to spend them, will be responsible—and happier, too (Schulz and Harrison 1984; Harrison and Schulz 1989). The UK has spent three decades trying to manage them in increasing detail and with decreasing autonomy for the component units of the health services. Scotland's efforts to work with rather than against professions might work as well or better, and might increase the public legitimacy of rationing while creating a role for management that is better aligned with medicine and therefore more effective. Second, it might align organisation with the development of medicine. When hospitals were primarily about palliative and remedial care rather than high-technology interventions (i.e. until recent decades), it made sense for them to be organised as independent, territorial units similar to hotels or schools. Much of what they did was catering, laundry, and basic personal and medical care. By contrast, now, medical treatment is increasingly specialised and hospitals have steadily less in common with hotels. Managed clinical networks respond to this logic—they try to allocate resource flows and activities according to the technical demands of the process rather than by territorial "patches." The shift from a bricks and mortar understanding of industrial organisation to one more focused on flexible networks has been visible in less complicated and professionalised private sector organisations for decades now. If hospitals are no longer building blocks but rather network nodes, then it is Scotland that is responding appropriately and it is England that is entrenching an outdated, industrial-era model. Scotland's effort to focus less on territorial areas and buildings and more on the nature of the work might look not so much like Old Labour corporatism as like internet-era innovation.

If Scotland's experiment works, it might get better health services and should get better value for money as its rationing increases in legitimacy and coherence. It is for this reason that Scotland is worth watching.

C. Capacity matters

Wales, on paper, is a radical experiment. A health service that focuses on local action to address the wider determinants of health, rather than simply treat ill health, is a radical shift in how health systems operate in the UK and indeed in much of the world. In practice, however, evidence is accumulating that Wales designed the blueprints for the most decentralised and localist health service in the UK and built the most centralised and micromanaged service.

The culprit is lack of capacity at every level. The National Assembly inherited its policymaking expertise from the Welsh Office, which was not a dynamic organisation compared even to the larger and more senior Scottish Office. This meant that the Assembly, once it had embarked on a radical programme of reforms, found that it lacked the capacity to make basic decisions in a timely manner. Important functions of the old Health Authorities were unallocated until weeks before the new organisation "went live" in April 2003. Hiring and nominations to the new boards strained the procedural and organisational abilities of Cardiff's overstretched officials. Its partners outside the NAW were then unable to pick up the slack. In Scotland, long-established networks of well-organised clinical elites were

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.

D. Disengagement is hard

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 length, and Wales is trying to share power and responsibility with local authorities and communities. In each case the government is trying not just to get good value out of the health budget but is also trying to find a way to extricate itself from the daily media storms and embarrassment that surround health services *everywhere,* but in the UK systems congregate particularly around the person of the minister. Localism, professionalism, and markets are all ways to disengage.

The paradox of disengagement is that it generally produces closer engagement. The degree of determined central intervention required to reorganise the system into its new, self-governing mode is so great as to leave the system more centralised than before. The paradigmatic case of this is the creation of the internal market under the Conservatives. The degree of purposeful central intervention required to form the system into trusts and impose goals on them was far greater than had been seen in any previous area of health policy. Giaimo and Manow quite rightly call the result not decentralisation or a market but rather "more state, more market" (Giaimo and Manow 1999). There is scant evidence that it created much of a market, but it did leave the government with a new array of policy tools that lowered the organisational cost of reorganisation. It therefore invited further central interventions, many of them in the perpetual quest to create a self-governing system that would work without further central interventions.

There are two minimalist ways around this problem. One is to presume that there can be political learning—that politicians will start to see the costs of organisational change as high and increasing. Former health minister Enoch Powell, as long ago as 1966, tartly expressed his view that no sane politician would want to hold the health portfolio (Powell 1966). His view should certainly appeal to ministers today. The ratio of meaningful, creditworthy actions to possible disasters is just too unfavourable. We can imagine simple political learning—that politicians will learn not to become involved in the grit of health services because it is too likely to

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.

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