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Health Policy in Wales – Distinctive or Derivative?

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This article examines the policy process in Wales prior to the introduction of a National Assembly for Wales and uses this as a framework for assessing the potential impact of devolution. Health and social services form the largest part of the budget of the National Assembly for Wales and the article focuses on health policy as a key area of interest for Assembly Members. The period 1992 to 1997 demonstrates an emphasis on managing both demand and finances thereby promoting the continued dominance, in terms of both resource allocation and prioritisation, of the acute hospital sector. The article then explores how far this has changed and what potential there is for changing this assumptive reality in a New Labour and devolved NHS.

Background

Whilst health care in the United Kingdom, at least prior to the introduction of devolution, is considered primarily to form part of what is termed a National Health Service, most studies have focused on the English part of the NHS. Yet somewhat different structural and policy-making arrangements have existed in the NHS for some time in other parts of the United Kingdom, that is Northern Ireland, Scotland and Wales. This is likely to be significantly enhanced by devolution and the creation of Assemblies and a Parliament in these countries.

Prior to devolution Wales, even more so than its Scottish counterpart, was often perceived as forming an adjunct of the English health service. However, it retained its own policy-making body in the Welsh Office with a Secretary of State responsible to Parliament in Westminster for many functions including health (Levitt, Wall and Appleby, 1999). The Welsh Office had both departmental and regional responsibilities within a Health and Social Services Department under the overall responsibility of the Secretary of State for Wales. Sir Graham Hart, in reviewing responsibilities for health for the National Assembly for Wales (NAfW), concluded that although the Secretary of State for Wales had exercised health responsibilities since 1969 policy and practice in Wales had not in fact diverged much from England (Hart, 1998).

The advent of devolution, crystallised in the Government of Wales Act of 1998, gave the NAfW a rather more limited remit than the Scottish Parliament with the latter having the opportunity to raise taxation and to enact primary legislation, neither of which is available to the National Assembly (Hannan, 2000). Of the areas devolved to the National Assembly, health consumes the largest part of the budget, 34 per cent, or £2.7 billion in 1999/2000 (Jervis and Plowden, 2000). Funding to Wales is based on the so-called Barnett formula which has latterly received criticism from both the NAfW and

other quarters (Richardson, 2000; Osmond, 2000). Wales spends about 13 per cent more per capita on health services than England, which may, in part, reflect the higher numbers of elderly people and higher levels of socio-economic deprivation which Wales experiences in comparison to England.

Welsh health policy in the 1990s

The first part of this article focuses on the study of the period 1992–1997, prior to the election of the Labour government of 1997 and the creation of the NAfW. The study is located in a qualitative approach to policy analysis, drawing primarily upon documentary analysis and in-depth interviews with key stakeholders within the NHS in Wales and the Welsh Office.

A key question that needs to be posed when examining the policy process in this period is what impact this had on changing or reinforcing continuity in the delivery of health services. The study revealed little evidence of major changes in service delivery, leading to the conclusion that resource allocation in health continued to favour the status quo, that is the acute hospital-based sector. This raises frequently discussed questions regarding the efficacy of the internal market with explanation for lack of change laid for some at the door of a market that was implemented with weak incentives and strong constraints (LeGrand *et al.*, 1998). However, as will be discussed, the internal market is an administrative 'red herring' with the reasons for the reinforcement of the status quo lying deeply within the value base of the policy community in Wales.

Change is seen to occur primarily on the margins of service delivery. Resource allocation and prioritisation combined with organisational and political attention perpetuated the dominance of the acute hospital-based sector even within the internal market. Whilst developing services and disinvesting from services was seen to consume a considerable proportion of managerial and political time there is little evidence of their impacting upon the quantum of service delivery. Developments were highly constrained both by government priorities and the ever-tightening financial framework within which the NHS had to operate.

The sanitised term of 'disinvesting' in health services also received much attention from the 'meat axe' rationing of the early 1990s through to continuing emphasis on clinical effectiveness, or more triumphantly 'excellence', as the grounds on which disinvestment decisions will be made. There is however little evidence to demonstrate how far the language of clinical effectiveness has actually impacted on the releasing of resources and thoroughgoing changes in patterns of service delivery.

Change where it does occur is seen to be in support of the continued dominance of the acute sector. Increased day surgery, locally provided services and open access services developed considerably during the 1990s. Although the provision of open access and more locally provided services can and have been linked to the continuing shibboleth of a primary care led NHS, they can more appropriately be placed within the context of the provision of hospital type services. This is strongly linked to what were the main drivers of government policy and managerial implementation – waiting lists, emergency admissions, and financial balance. Whilst concepts of health gain, a primary care led NHS and clinical effectiveness formed part of a strategic and generally rhetorical policy agenda, these three policy drivers provide the context within which resource allocation decisions were made.

The three policy drivers, of waiting lists, emergency admissions and financial balance, can be linked to the root of the historic problems of the NHS – the need to manage demand and supply of resources both financial and service based (Dennis *et al.*, 1994; Klein, 1995; Webster, 1998). The historical settlement of the NHS in 1948, whilst emphasising the role of general practice nonetheless placed the acute sector at the forefront of the NHS. In part this may be due to the compromise of the position of GPs as independent contractors and the retention of what might be termed community services with Local Authorities until 1974 (Levitt, Wall, and Appleby, 1999; Webster, 1998).

The internal market was hailed as a radical departure for the NHS although reforms predating and subsequent to it have also laid claim to this title. However, in Wales the introduction of the market did not impact on the continued emphasis on the hospital component of the NHS. Indeed it could be argued that given the value base that underpins the NHS it was never intended to. In an organisation as large and complex as the NHS, even in the smaller principality of Wales, reforms will mark an incremental step in the development of the health service. The notion of radicalism or indeed rationality in health policy seems to be little more in NHS Wales than the prescriptive approach it is held up to be by its critics (Lindblom, 1980).

Government was seen to use a wide range of formal and informal mechanisms through both its executive and political arms to transmit policy directives to those working within the NHS in Wales. Whilst this included the formalities of circulars, letters and annual reviews, more importantly it involved unminuted meetings, briefings and telephone calls between civil servants and health service managers and clinicians and between politicians and their appointees the chairs of Health Authorities and Trusts.

The articulation of priorities through the formal mechanism of Welsh Office circulars and DGM letters provides a written account of the trends and flavours of the period. The three areas of waiting lists, emergency admissions and financial balance dominate but are by no means exclusive, and in fact are located within a plethora of priorities. Despite the best attempts of at least one Health Authority during the period to apply 'rational' health economics to priority setting, Trusts and Health Authorities still found themselves in what was termed by one interviewee as 'the year of the fractured femur'. This multiplicity of priorities, however, seems merely to have reinforced the dominance of the main three policy drivers.

These mechanisms allowed the, at this point, central government priorities of managing demand and efficiency to permeate throughout the NHS in Wales. However this raises the question why these emphases would appear to be so successfully transmitted when other priorities never emerge from the starting gate. This can be linked to some clear facilitators notably:

- clear and quantifiable targets;
- linking targets to organisational and job performance;
- ringfenced money;
- consistent reinforcement of targets through formal and informal mechanisms.

However of itself this is not sufficient explanation of why these priorities continue to dominate and shape the NHS in Wales.

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The explanation for this, and one which raises important questions for changes under the devolved administration, lies in the existence of a closely integrated policy community within the NHS in Wales. A clear set of vested interests were institutionalised within the Welsh Office in the form of civil servants, administrative and professional, and in politicians in the shape of the Secretary of State for Wales and his supporting ministers. The executive and indeed the non-executive appointments to the boards of Health Authorities and Trusts further reinforced these interests.

Within these policy communities the distribution of power emerges as a key determinant of decision making. The medical dominance of the decision making process is not revelatory and whilst policy processes can be seen to be incremental, plural and characterised by bargaining and compromise the distribution of power continues to be weighed heavily in favour of Alfords 'professional monopolisers'.

Thus Ham's 'dominant incrementalist mode' seems somewhat inevitable in such a complex organisation as the NHS but, as he has recognised, this is not of itself sufficient explanation (Ham, 1999). An explanation of the continued dominance of the hospital sector can be seen to lie in the values of those within the policy community in constructing the 'assumptive reality' of the NHS (Young, 1977).

It seems likely that these values remained located within a view of the NHS that it comprises doctors, nurses and most importantly hospitals. Waiting lists offer a tangible representation of this view and symbolically demonstrate the success or failure of any government in managing what is still a sacred cow amongst much of the British population. Thus the perpetuation of the status quo is not just related to the difficulties of changing a monolithic organisation, although that must play a significant part. It is also rooted in the psyche and value base of British society but more importantly those key players in health policy formulation and implementation. This value set precludes other issues from making any real headway on the NHS agenda and are of themselves institutionalised into health policy decision making by structures, organisations and vested interests.

It could be speculated that this value base has been predominantly constructed by the most powerful of vested interests – the medical profession and in particular hospital consultants. As Lukes (1974) theorised, the most effective use of that power is to control the production of ideas and the maintenance of a version of reality that favours the interests of this specific group. Thus the biomedical model of disease defines the purpose of the NHS, which perpetuates the dominance of the acute sector where those with clinically defined ill health are treated.

However, this contention that the 'assumptive reality' of the NHS has been constructed by the medical profession is not without challenge, and it can be further speculated that the medical profession are as much recipients of this dominant ideology as constructors of it. The difficulties of getting other health related issues on to the agenda may not necessarily be the product of a conscious decision regarding the exclusion of other issues by the 'elite' that is the medical profession. Indeed politicians, both in an individual guise and as party politicians, need to be added to the policy community dominated by Hogwood and Gunn's (1984) triumvirate of civil servants, health service managers and the medical profession.

What emerges is a high level of convergence amongst members of the policy

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community regarding the nature of the NHS itself. The difficulties experienced in progressing other issues can be seen to lie in this dominant consensus or hegemony in respect of what the NHS is and what it should be. Thus issues are precluded by a combination of social forces and organisational practices, structures and processes (Lukes, 1974) which are institutionalised into the NHS in Wales and which of themselves contribute to the manipulation of society's consciousness (North, 1997). This contributes to general support for the main drivers of Welsh health policy.

The findings of the study and the suggested underpinning theoretical explanation for a particular construction of the NHS in Wales could simply be consigned to Wales itself and to a period of time now past. However, it raises questions both for the NHS in the United Kingdom as a whole and for the future of Welsh health policy in the era of devolution.

Similar work on the NHS in England (North, 1997, 1998; Redmayne, 1992, 1995, 1996) did not uncover substantially differing findings. The study shows itself to have resonance with previous studies both evaluating the internal market (LeGrand *et al*, 1998) and prior to the introduction of the internal market (Ham, 1980; Haywood and Renade, 1985; Haywood and Alaszewski, 1980).

This is perhaps not surprising given the close relationship between the former Welsh Office and English governmental departments. Thus the Welsh Office has been seen to more closely follow the lead of the DHSS and subsequently the DoH (Hunter, 1982). Much of this can be attributed to historical circumstances. The Welsh Office came into being as a separate entity relatively recently in 1964 and only took over responsibility for health and personal social services in 1969 and 1971 respectively. Nor were the responsibilities devolved to the Welsh Office as extensive as those devolved to the Scottish Office over a hundred years ago. Moreover Scotland has maintained its own legal system while that of England and Wales is unified. The proximity of Cardiff to London in comparison with Edinburgh, and population flows in and out of the principality, have also contributed to a closer relationship with English government.

Health policy in a devolved Wales

It has been suggested however that there are important differences between Wales and England that will make for distinctive policy making. In the run-up to devolution Hazell and Jervis (1998) suggested that both Wales and Scotland had certain advantages over England. The combination of tight political and professional networks and the ability to work across departmental boundaries were thus both cited as making for quicker and easier agreement over policy and strategy. The key question for Wales is whether the advent of devolution will make for more distinctive policy making from its former Westminster and Whitehall focus. More profoundly it raises the question of whether this can also reconstruct the value base which underpins the NHS in Wales to move away both in terms of resource allocation and prioritisation from the dominance of the hospital sector.

Hazell and Jervis (1998) suggested that in devolution there was the possibility of either a minimalist or a radical approach. Those prophesising few changes suggested that devolution provided Wales with few truly 'new' freedoms and that the difficulties of negotiating and mediating change through professional stakeholders would not become any easier under devolution that it had been before. Moreover concern was expressed

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that Labour, likely to be the ruling party, would feel constrained not to undermine the policies of the Labour government in London. Concern was also expressed regarding the calibre of potential Assembly politicians and the potential for high levels of parochialism to impede change.

Hazell and Jervis saw the potential for more radical change to emerge from the closely integrated 'policy villages' already described and the ease of co-ordinating across departmental boundaries. However, it is debatable whether these policy villages, given the value base which underpins them, can ever act as agents for radical change and may in fact offer an even stronger force for reinforcing the dominance of the acute hospital sector.

Devolution has only been in place for a very short time and it is therefore difficult to establish whether the minimalist or radical approach has dominated. Care also needs to be exercised in evaluating what is still an emerging institution in the National Assembly for Wales. There are however some issues which have emerged in the early days of devolution which may provide some understanding of the potential for developing a distinctive Welsh health policy and of changing patterns of working and ways of thinking.

Following the first elections to the National Assembly for Wales in May of 1999 the Labour Party emerged as the largest party, as predicted, but somewhat surprisingly without a working majority. The consequent 'hung' Assembly had important implications in creating an environment in which it was difficult to make and implement policy and ultimately resulted in the Liberal Democrat–Labour coalition (Hannan, 2000). Whilst this facilitated policy making, the consensual nature of the politics which underpinned it seems likely to have reinforced the essentially conservative value base previously described. These party political and constitutional machinations created something of a policy vacuum and this can also be associated with the steep learning and organisational curve which the Assembly faced.

Responsibility for health and social services lies with the Minister and the Committee for Health and Social Services. The wide remit and complexity of the issues faced by both the Minister and the Committee, combined with the constraints placed by a 'hung' Assembly, may have impeded the making of policy decisions. The work on child abuse engendered by the North Wales Inquiry and the development of a Children's Commissioner, something that was unique to Wales, are cited as major achievements of the Committee (Osmond, 2000; Richardson, 2000). However, in terms of the NHS itself the most noted development was the extension of free eye tests and free prescriptions, despite advice to the contrary from the Chief Medical Officer.

In a potential break from the orthodoxy of managing acute sector demand the Minister in particular emphasised what has been termed 'joined up working' focusing on partnerships between health, local government and the voluntary sector (Burnett, 2001). It could be suggested that this emphasis combined with other factors has resulted in a situation in which the waiting list position in Wales worsened particularly in comparison to the English NHS. Unsurprisingly therefore by the early part of 2000 waiting lists came increasingly to the fore and to preoccupy the Executive of the Assembly. In common with pre-devolution days additional monies were found and clear targets to reduce the all Wales total waiting list by March 2001 were put in place. The date in the light of the possibility of a May 2001 election appears to be more than coincidental and could be seen to demonstrate the triumph of an emphasis on waiting list targets over other

priorities. The waiting list commitment laminated on the general election pledge card proved to be as resonant in Wales as in England.

Recent articulations of overall government health policy are provided in the English National Plan (Secretary of State, 2000) and the Welsh National Plan *Improving Health in Wales* (Minister for Health and Social Services, 2001). These plans may offer some indications as to future government intentions. The English plan, whilst being tied to a large increase in funding and with some interesting emphases on achieving national inequalities targets, still focuses on increased beds, hospitals, nursing and medical staff. It also continues the emphasis on waiting times with more stringent targets for in-patients and out-patients and extending these to the primary care sector with targets for GP appointments. The Welsh plan, whilst it appears to strengthen centralised control and performance management systems. lacks the more stringent targets of its English counterpart. In part this can be related to Wales not achieving the previous targets. The plan does eliminate Welsh Health Authorities and strengthens the role of Local Health Groups/Boards thereby giving organisational form to a primary care led NHS.

Both Wales and England have seen the introduction of primary care led commissioning organisations in the form of Local Health Groups/Boards and Primary Care Groups/Trusts. There must be some debate as to whether the new organisational forms engendered by the creation of LHG/Bs and PCG/Ts can therefore offer the potential to change the status quo of resource allocation and priority setting. Ferlie (1999) suggests that there may well be the beginnings of a move away from the large-scale professionalised bureaucracy of the past to a new pluralistic NHS in which services are provided on a smaller scale with the consequent erosion of professionalisation and public service values. However, it is contentious whether new organisational forms can of themselves shift the value base surrounding the NHS and this can be linked particularly to the role of government, both centrally and devolved, in priority setting and resource allocation. Changing this value base seems likely to require thoroughgoing changes in structures, processes and organisational practices if indeed such a change will be ultimately reconcilable with society's interests.

Conclusion

The assumptive reality of an NHS dominated by hospitals and their doctors and nurses appears relatively unshaken from the inception of the NHS in 1948. Organisational changes whether within a UK or devolved NHS seem to date insufficient to alter a value base entrenched and reinforced by health policy communities. The NHS in both Wales and England appears yet again to be 'in crisis'. Familiarly much of this focuses on waiting lists. In England the increasing use of the private sector is offered as a transitional but quite possibly permanent solution to the capacity problems of the hospital sector. Whilst the use of the private sector appears more problematic in the heartlands of 'old Labour' the quest to increase capacity is just as pressing.

The NHS when constructed as a national hospital service may have within it the seeds of the many crises, which it has and continues to face. Where health is equally constructed in a bio-medical model increasing demand forms part of a world expecting cures, striving for physical perfection and resisting the inevitability of death. To move beyond the preoccupation with hospitals offers the potential to re-discover and make real structural explanations of ill health. The link between poverty and ill health still remains

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at the level of rhetoric and the emphasis within the NHS on hospitals conspires to divert attention from this reality. The high levels of deprivation experienced in Wales press for a more distinctive Welsh health policy. However, it seems debatable whether devolution will significantly shift the Welsh health policy process to allow for inequalities in health to truly permeate the future policy agenda.

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