Devolution & Regionalism in Socialised Medicine: A Comparison of UK & Italy

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Abstract

This paper is a comparative analysis of health care and policy in two European countries, the UK and Italy, which, at the country level of analysis, appear to be remarkably similar: in size of populations; GDP/Capita; total spend on health care as a percentage of GDP and public spend as a percentage of total spend on health care. Both countries are exemplars of socialised medicine: each has a single payer system financed in great part by general taxation, with nationally agreed systems for paying doctors, with General Practitioners providing primary care and acting (or supposed to act) as gatekeepers to hospital and extra-hospital specialists. We describe the very different subnational arrangements used within the UK and Italy for governing the delivery of health care. Italy has 21 regions with widely different sized territories, populations, geographies, GDP/Capita. Regions have considerable autonomy over the governance of the delivery of health care, but the national government has important powers for setting a guaranteed basic national health care entitlement. In the UK, following devolution, there are Assemblies in Wales and Northern Ireland, and the Scottish Parliament. The UK Cabinet and UK Parliament make decisions: for the UK on foreign policy, defence, welfare payments, and taxation; and for England on public services (including health care). We compare how policy differences have emerged subnationally under regionalism in Italy and under devolution in the UK; and, where evidence is available of outcomes, report what we can learn from these “natural experiments” and from comparing these two countries.
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Introduction

Cross country comparison must surely have nobler motivations than simple curiosity, but it may be difficult to identify just what these are. Ideally comparisons would have an explanatory scope in the study of this relationship between dependent and independent variables. Paul Pierson in discussing the significance of federal institutions for social policy, suggests that federal institutions are “embedded” in their context and are affected in their functioning by the context in which they work (Pierson, 1995). In this regard, we have to recognise that there is no unique form of federalism – there are so to speak “national brands”. Comparing key aspects of these different national brands may help us to isolate their specific effects. This paper examines form and context in the national health services in two European countries, the United Kingdom (UK) and Italy, and briefly considers a number of questions relating to constitutions and institutions regarding public accountability in the use of health care resources; strategies for promoting efficiency in the public health sector and devolution in health care.

The two countries examined here are similar in terms of population - UK 63.0 million and Italy 60.5 million. GDP per capita is also similar - UK $35.5 and Italy $32.1. Each country spends broadly the same percentage of GDP on health (UK 9.8%, Italy 9.5%). A similar proportion of total health expenditure in both countries was publicly financed (83.4% in UK, 79.6% in Italy) [OECD 2010 – data for 2010]. Both countries are well off by international standards, but very low or negative GDP growth rates in Italy over the last decade mean that the public health system in that country may have increasing difficulty in the future in securing resources for public health care.

Both the British and the Italian national health services are in large part financed by general taxes authorised by Parliaments which means that sets of “golden rules” have been established. This has also created a single payer system. General practice doctors (GPs) act as gatekeepers to specialists and there are nationally agreed systems for paying doctors. Each country has made changes to increase the autonomy over the way the systems of health care are governed. Both national health services, over and above being tax financed, provide universal and comprehensive care. One major difference between the two countries is the constitutional arrangements for governance that have developed over time within each country. Italy has developed a
form of regional governance through twenty one popularly elected regional entities. Six of those are special statute regions and enjoy more autonomy in terms of powers and tax authority. There is a problem of skewed fiscal federalism with certain regions in particular continuing to overspend the budgetary allocations from the centre.

In contrast, the UK has created a system based on devolution to governments of historic nations: to the Scottish Parliament, and Assemblies in Wales & Northern Ireland. The rationale for devolution was that this was seen to be a way of preserving the Union in response to nationalist pressures, particularly from Scotland. The UK’s constitutional arrangements differ from those of Italy three crucial respects. First, there is no English Parliament to represent the interests of English citizens. Second, there is no overarching system governance of the four devolved NHSs. Third, the UK countries are of very different sizes: in terms of their populations (2010 estimates\(^2\)), there is one giant, England, 52.2 million; and three pygmies, Scotland, 5.2 million, Wales, 3.0 million, and Northern Ireland, 1.7 million\(^3\). This paper is thus about how two countries, similar in many respects at the national level, have implemented different systems of subnational governance of health care and about the consequences of these differences.

To facilitate the analysis, the body of the paper is divided into two parts, one for Italy and one for the UK. Each part outlines the arrangements for sub-national governance by the 21 regions in Italy and the four countries of the UK. It then considers each country in terms of different pressures for accountability which are summarised in the concluding section

**Italy**

**Constitutional Arrangements for Regional Government**

The Italian Constitution envisages a multi-tiered system of government: the central government or the State, the regions and local government\(^4\). There had been considerable debate in the past on whether to create a regional level. Italy was


\(^3\) A possible explanation for the persistence of these bizarre arrangements is that devolution was seen as a first step to be followed by the introduction of regional governments in England. But that was rejected in a referendum so heavily, when tried in 2004 in the North East, that it is now off the political agenda for a generation. See Anonymous (2004) *North East votes “no” to assembly*. Friday, 5 November, 2004. <http://news.bbc.co.uk/1/hi/uk_politics/3984387.stm>

\(^4\) Actually there is a fourth level envisaged, the provinces, but this has no relevance for health.
relatively united - in the 1860s – and there was wide spread anxiety about the risk of fuelling centripetal forces with the creation of the regions. On the other hand Italy’s history of subnational government, especially at the local (communal) level meant that subnational forces had to be catered for. After World War II, there were strong forces pressing for autonomy: the large islands (Sicily and Sardinia) and territories with borders and strong ethnic affinities with foreign states (Trento, Bolzano, Val D’Aosta, Friuli-Venezia Giulia). There were furthermore geopolitical factors at work. Regionalism was looked at with interest as a means to prevent repetition of the concentration of power at the centre. On the other hand, it was feared that regionalism would reinforce the power of left wing parties traditionally stronger at the subnational level and contribute to a change in the balance of power in the Southern Mediterranean area (Sources).

Six special statute regions with special powers were created between 1946 and 1965 and fifteen ordinary statute regions were set up in 1970. Members of the Regional Council and the President of the Executive are elected by popular vote. The Regional Council has legislative powers but this level of government has limited tax powers. Table 1 lists the 21 Regions, which vary significantly in terms of population size (although not as much as in the UK), ageing of the population, regional income per capita and a measure of inequality of income. Perinatal mortality is given as a kind of token indicator of the quality of care. Regions share responsibility with central government for health care.
### Table 1

<table>
<thead>
<tr>
<th>Region</th>
<th>Resident Population</th>
<th>Ageing Index (1)</th>
<th>GDP per Inhabitant (euro)</th>
<th>Regional GDP (Italy=100)</th>
<th>Perinatal Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2009</td>
<td>2009</td>
<td>2009</td>
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<tr>
<td>Piemonte</td>
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<td>178.7</td>
<td>21,672</td>
<td>108.1</td>
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<td>128.2</td>
<td>149.7</td>
<td>26,756</td>
<td>133.4</td>
<td>4.7</td>
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<td>141.1</td>
<td>25,251</td>
<td>125.9</td>
<td>1.9</td>
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<td>Liguria</td>
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<td>232.0</td>
<td>21,052</td>
<td>105.0</td>
<td>2.6</td>
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<td>108.5</td>
<td>27,169</td>
<td>135.5</td>
<td>2.1</td>
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<td>Trento</td>
<td>529.5</td>
<td>125.4</td>
<td>24,294</td>
<td>121.2</td>
<td>1.3</td>
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<td>Veneto</td>
<td>4,937.9</td>
<td>139.8</td>
<td>23,187</td>
<td>115.6</td>
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<td>Friuli-Venezia Giulia</td>
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<td>22,169</td>
<td>110.6</td>
<td>1.3</td>
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<td>24,396</td>
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<tr>
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<td>22,066</td>
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<td>1.8</td>
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<td>Marche</td>
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<td>20,487</td>
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<td>23,805</td>
<td>118.7</td>
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<td>Abruzzo</td>
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<td>16,311</td>
<td>81.3</td>
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<td>Molise</td>
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<td>175.8</td>
<td>15,948</td>
<td>79.5</td>
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<td>12,776</td>
<td>63.7</td>
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<td>66.0</td>
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<td>13,179</td>
<td>65.7</td>
<td>3.2</td>
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<td>122.2</td>
<td>13,631</td>
<td>68.0</td>
<td>3.2</td>
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<tr>
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<td>158.6</td>
<td>15,895</td>
<td>79.3</td>
<td>2.2</td>
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<tr>
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<td>60,626.4</td>
<td>144.5</td>
<td>20,043</td>
<td>100</td>
<td>2.4</td>
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</tbody>
</table>

Sources:
(1) ISTAT (2012), Noi italiani, Rome, 2012, p. 41
(2) Op. cit., p. 42
(3) Popolazione >65/popolazione<15/\%.
Law 833/1978, the principal statutory basis for the SSN, envisaged State responsibility for funding and strategic planning. The regions were to be responsible for administrative matters, while the local government and the local health authority (Unità Sanitaria Locale -USL) would take care of the actual delivery of health care itself. It seemed at first as if the regional function was essentially empty of content. The majority of regions had been created only in 1970 and were staffed by employees made redundant with the abolition of the health insurance funds with little experience on how to administer a regional health service. Real power, it was imagined, would lie with the State and the local government and USL. The regions would serve as peripheral offices of the State.

The SSN was set up in 1978, replacing a bankrupt Bismarckian social health insurance fund system and was the only case of abandonment by a major European country of the health social insurance model (Source). The SSN is strikingly similar in some respects to the British NHS although there is no official record of conscious policy transfer having been made (McCarthy, 1992). In the Parliamentary debate and in the Reform Law great emphasis was given to key principles of the British model – namely those of comprehensiveness, universality, gratuity at the moment of consumption and tax based funding. Finally, but certainly not last in order of importance, the amount of national resources to be dedicated to health care was to be set by central government and the political-parliamentary process rather than endogenously by the health care system itself.

That is not exactly how things worked out in practice. The regions were for some time incapable of assuming a constructive or dynamic role vis-à-vis the State and the USL, the new local health authorities. But nevertheless they insisted on their prerogatives and soon began to appeal to the Constitutional Court against alleged State interference in administration and organization. Inefficient utilization of resources at the local level is well documented and was rampant (Source). But, the regions, backed up by the courts, resisted central interference as a matter of principle. And the State, with its constitutional responsibility to fund health care, found itself obliged to finance to perennial deficits of the regions. The Constitutional Court took the position that the State had the duty to specify a priori the spending needs of the regions (essentially an entitlement) or assume the role of a third party payer, (rather like US Medicaid). The State found itself in the position of having to fund spending decisions taken by other levels of government without having any say on the matter. A gigantic accountability problem had been created. This situation had its appeal for those likely to benefit from uncontrolled spending, politically as well as financially, and reform bills appeared on the parliamentary agenda as early as 1983, only to languish in the committees. Weak
coalition governments are not reformers. The Italian situation was in extreme contrast with British one.

Problems of Accountability in the Original Constitutional Arrangements

A factor to be taken in account when addressing the question of accountability in the SSN is how it has handled the question of vertical (industrial) integration. A national health service is, in economic terms, an integrated organization formed by the voluntary or cohesive acquisition of producers and finances. In the case of health care, integration involves and absorbing merging hospitals and clinics, laboratories, ambulatory specialist care facilities, general practice doctors. Hospitals and other facilities became part of one single organisation. Doctors and other health professionals became employees or were contracted with the integrated organization. It also involves the merging of different functions – production, financing, planning etc. The hope is that vertical and horizontal integration will produce economies of scale and coordination, reducing transaction costs generated in dealings with markets, including opportunism attributable to problems of contracting. Hence the aim of the SSN as an integrated organisation is to satisfy the key principals of comprehensiveness, universality, gratuity, at the moment of consumption, efficiency of production and provision. These principals go to make up the notion of “good performance”, even though this is difficult to quantify.

The degree of vertical integration characterising the SSN at its creation in 1978 was probably significantly lower than that characterising the NHS in 1948. For example, the State in Italy was politically and legally constrained from coercively integrating private hospitals. Yet, at the same time it was obliged to contract with certain types of these hospitals. In certain geographical areas and for certain clinical specialties, the SSN had no alternative, but to supplement its capacities with contracted private providers. A source of inefficiency was the use of a single national contract to regulate relations between the SSN and a given category of provider rather than using bilateral contracts. This created ample room for opportunistic behaviour. To give an idea, at the time when Italy was introducing internal markets in the SSN (from 1994 on), as much as 39% of total bed capacity of SSN for angiology and 27% of total beds for cardiology and cardiac surgery was located in the private sector and there were wide inter-regional differences (Silvestri, 1999).

However the root problem with the SSN for what regards accountability is probably that the line of control between the centre and periphery has historically been weak. SSN’s funding is provided by the centre which lacks – unlike in the UK – the power to enforce that these funds are used appropriately for the purpose that the Parliament
intended. For the first decade and more of the life of the SSN, responsibility for spending decisions lay mainly with the local health authorities. This was a new organ created in 1978 and being local was assumed to have superior knowledge of local health care needs. The problem lay in the fact that the local health authorities were open to political abuse and corruption, frequently a source of funding for the local party political machines (Source). The region was formally in charge of organizational and administrative matters, but was the new kid, still feeling his way around the block.

The Subsequent Quest for Increased Regional Accountability

The financial legacy of flawed policy design was all the more unacceptable the more pressing became the external budget constraint deriving from membership of the European Monetary Union. A crude measure of the problem is the degree to which planned expenditure targets set by the Ministry of the Treasury have been overshot. The situation in the 1980s was particularly desolate. Between 1980 and 1992, the annual aggregate deficit for the SSN averaged about 10% (Veronesi, 1994, p. 179). After a brief period of surplus (1991-1995), aggregate deficits began to grow once again in the late 1990s and early 2000s. For long the reaction to chronic overspending was ad hoc and improvised. The dimensions of the “bailing-out” operation eventually were substantial. For example, Bordignon and Turati (2009, p. 308) report that “it took 8 years to cover 80% of the average regional health deficits accumulated by the regions 1986 up to 1994”.

Under article 3 of Law 833 of 1978, the State had to set levels of care that the SSN has “comunque” (“in any case”) to guarantee to all citizens. This apparently innocuous obligation was interpreted by the Constitutional Court to give great freedom to define what care was necessary to satisfy article 3 and, therefore what it means in terms of total spending. In the US this would be called a “sleeper clause”. The State had to define an entitlement or leave lower level governments determine total spending via their myriad spending decisions.

This situation persisted until 1992 when reform legislation introduced pro-market reforms in health care and at the same time increased the powers of the regions in the field of health. Under the new regime, the State would set a national entitlement of services that the regions were obliged to provide and the State would make sure that the regions had the necessary finances to do so. The regions could provide services not included in the entitlement but spending in excess of this guarantee had to be met by the region from own-source revenues. The 1992 law contained measures for augmenting these revenue sources. But there was continued failure to agree on how to go about setting the entitlement and identifying financial responsibility for spending
overruns, and plans for a form of fiscal federalism ran up against fears by the national Ministry of the Treasury of the implications of significant sub-central tax powers for the external budget constraint.

Only after the definition of the entitlement had been given constitutional status in 2001 and its definition made an exclusive power of the State, did an entitlement become workable. A State-region accord was signed in August 2001 which envisaged the two parties working together to give the entitlement operational content and to divide responsibility for eventual deficits Called “livelli essenziali di assistenza” (essential care levels - LEA), they were published for the first time in November 2001 when it was estimated, using the new methodology, that the regions had responsibility for 87% of the deficit (References).

The LEA were to become a key tool in Italian health policymaking. One goal of the 1992 health reform was to shift responsibility and therefore also the political blame for expenditure containment down to the regions. It also aimed at protecting the national interest in health care and the spirit of the 1978 reform. It was feared that regionalism might lead to an erosion of the nation state and the development of 21 regional health services (References). However, also the LEAs had a serious design flaw, namely they were supposed to guarantee health care in a decentralised setting, but was also intended to contain regional expenditure. The obligation of the State to guarantee the LEAs’ financial basis made it ambivalent in resisting expenditure increases. The State found itself in the impossible position of being neither fish nor fowl but trying to be both.

Another much tougher intergovernmental accord was signed in March 2005. This resulted in the State negotiating with the regions with deficit on the actions necessary to reduce their deficit and the application of more stringent conditions for them receiving aid in paying off the deficit accumulated in the period 2001-2005. As in 2001, under the 2005 accord the regions, in order to receive financial aid agreed to take measures rationalising resource use like hospital rationalisation, tighter controls over drug prescription, hiring freezes, introduction of hospital system accounting systems and they had to join a nationally uniform and standard data collection system. Spending began to vary significantly between regions reflecting among other things, differences in their capacity to manage health expenditure and in the factors causing the deficits (Tediosi et al, 2009). This was reflected in differences in the size of the deficits. Information on the activities by the regions over the period 2005-2010, were collected by the offices of the Chamber of Deputies over the period 2005-2010 (Presidenti delle Assemblee, 2010). These data suggest that many regions, mainly in the North, have matured and are showing a growing capacity to design and
implement, on their own, quite sophisticated policy tools. They seem able, that is, to engage in “social learning” (Hall, 1993).

From 2005, grant of aid to chronic and/or high deficit regions was made conditional on a region taking part in the new Budgetary Balance Plan Programme (Piano di rientro). Deficit spending began to vary significantly between regions reflecting among other things, differences in the size of deficits. The Plan has to be prepared in collaboration with a bank approved by the Treasury and with experts chosen by the Treasury and it had to satisfy tight data reporting requirements. Any region running a deficit of 5% or more of planned spending was classed as a “region in difficulty”. Three such regions accounted for 75% of the total deficit in 2006 - Lazio, Campania and Sicily. Another seven regions had Plans approved between 2007 and 2010. Five regions were subject to “commissariamento” between 2008 and 2010, that is placed under central government administration for having failed to implement their Plan (Corte dei Conti, 2011). “Regions in difficulty” are in effect under surveillance and can in an importance sense be considered to have surrendered temporarily their sovereignty. The Program has passes the test of constitutionality since formally speaking the choice to participate is optional. However, to decide otherwise would be tantamount to declaring bankruptcy. The universe of regions is monitored and any region can be investigated. In 2011, nine regions were defined to be “in difficulty” (Corte dei Conti, 2012). The Programme’s approach may produce predictable results for some regions. For example, Lazio’s problems may be in part the presence of Rome in its territory and therefore too many hospitals and staff, while for Sicily there is the cost generating effect of organised crime. Such cases may require longer term solutions than those envisaged with the Budgetary Balance Plan Programme.

The UK

Constitutional Arrangements for Devolution

Powers were transferred to the Scottish Parliament and Welsh Assembly on 1st July 1999; and to the Northern Ireland Assembly on 2nd December 1999. As a consequence, in the UK there are four elected bodies accountable for the four NHSs: the Westminster Parliament with representation for each UK country is accountable for the English NHS, the Scottish Parliament for the Scottish NHS, and the Welsh and Northern Irish Assemblies for the NHSs in Wales and Northern Ireland. The Westminster Parliament is also accountable for UK-wide policies on the economy (including public spending and taxation), foreign affairs, defence and social security. The other bodies are responsible for what we describe as “devolved services”, which
include health, education and local services (such as social services, transport, refuse collection and disposal)\(^5\). The Scottish Parliament has always had a wide range of legislative powers and is free to legislate on all matters except those reserved for Westminster, which for health and health care include regulation for almost all the health professions. The Assembly in Northern Ireland can also legislate except for reserved matters. The powers of the Assembly in Wales were more circumscribed but have now been extended, by the Government of Wales Act 2006 to cover devolved services\(^6\).

As we mentioned in the introduction, these arrangements lack key elements of normal federal governance: there is no basis for agreeing what should be the UK-wide elements of policy for devolved services versus those to be determined within the constituent countries of the UK and there is no elected body for England\(^7\). This anomaly was forcefully illustrated by the introduction of two controversial policies implemented by the Blair government in England only: NHS Foundation Trusts (that aimed to free hospitals from hierarchical control by the Department of Health subject to scrutiny by an independent regulator) in July 2003\(^8\) and the introduction of tuition fees for undergraduates in January 2004\(^9\). The Blair Government’s majority in the House of Commons depended on votes from MPs from Scotland and Wales, but these policies were opposed by the devolved governments in Scotland and Wales.

**Accountability of the Four NHSs**

Another peculiarity of devolution is that it is essentially a political arrangement with virtually no fiscal devolution: the NHS is financed by general taxation and national

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\(^5\) The full set of devolved services include education and training, fire and rescue services, health services, highways and transport, housing, local government, social welfare, planning (except major energy infrastructure) and water supplies – agriculture, fisheries, forestry, culture, including the Welsh language and ancient monuments, economic development and the environment.

\(^6\) See https://www.gov.uk/devolution-settlement-wales.

\(^7\) The latter anomaly is known in the Westminster Parliament as the West Lothian question, as articulated by the MP Tam Dalyell in the House of Commons: that is, why should MPs from non-English constituencies be able to vote on policies for England (for health care, education and transport); when English MPs cannot vote on these policies for each devolved country (as these are matters for their own Parliament and Assemblies), even though their finance comes from the budget for the UK? In a debate on devolution in November 1977, Mr Dalyell said: "For how long will English constituencies and English Honourable members tolerate… at least 119 Honourable Members from Scotland, Wales and Northern Ireland exercising an important, and probably often decisive, effect on British politics while they themselves have no say in the same matters in Scotland, Wales and Northern Ireland". See http://news.bbc.co.uk/1/hi/uk_politics/7702326.stm


insurance contributions on a UK wide basis. These arrangements mean that there are in essence two different systems in determining NHS budgets: one for England, and another for the devolved countries. For England, the NHS budget is the outcome of UK Cabinet agreements on public spending and taxation for the UK, following negotiations between HM Treasury and the Department of Health for England. The global allocations for “devolved services” in the devolved countries have been determined with reference to the Barnett formula, which is based on the principle that “growth” in resources for “devolved services” would be allocated to each country in proportion to its share of the UK’s population, with annual per capita spending increases derived from the percentage increase granted to the English baseline. Each devolved government then decides how much of its global allocation ought to be allocated to the NHS. This means that the governments of the devolved countries could decide to spend extra money derived from decisions designed to improve NHS performance in England on other devolved services (e.g. no tuition fees for Scottish undergraduates at Scottish universities).

The UK’s peculiar constitutional arrangements create two different kinds of inadequate systems of accountability. Governments of the devolved countries have direct political accountability for devolved services but no accountability to the UK Treasury. As there is no English Parliament, political accountability for these services in England is exercised through elections to the UK Parliament only, which involve both English and UK-wide issues (such as the economy, spending on social security, and defence and foreign policy). But the government in England is accountable for its spending on public services to the UK Treasury.

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10 Scotland only has very limited powers for raising extra taxes, which have not yet been used; the report from the Commission on Scottish Devolution recommended “that over one third of devolved current spending would be funded by taxes decided and raised in Scotland” (p. 8) See the Report from the Commission on Scottish Devolution (Chairman Sir Kenneth Calman) (2009) Serving Scotland Better: Scotland and the United Kingdom in the 21st Century. Edinburgh: Commission on Scottish Devolution. <http://www.commissiononscottishdevolution.org.uk/>

11 The Barnett Formula was seen, at its introduction as a short-term measure, but continued after devolution was enacted twenty years later, and has remained in place largely unaltered for thirty years. A formula designed for the long-term ought to take account of the relative needs of countries' populations. The Barnett Formula fails to do so, and this is why the House of Lords Select Committee on the Barnett Formula concluded that it should “no longer be used to determine annual increases in the block grant for the United Kingdom’s devolved administrations” (page 7). The Treasury's two studies of needs assessment in 1979 and 1993 were disregarded, but, if implemented would have meant a reduction in allocations relative to England in both 1979 and 1993 for Northern Ireland and Scotland; and an increase in spending in Wales in 1979 but not in 1993. Although in principle, the design of the Barnett Formula implies gradual convergence in per capita spend, this did not happen for two reasons. First, relative populations were not updated until the 1990s, despite significant changes (e.g., Scotland's share of the UK population declined from 9.3 per cent in 1976 to 8.7 per cent in 1995). Second, the formula did not determine all allocations of devolved public spending: there were extra allocations negotiated bilaterally with the Treasury outside the Formula, in particular to cover public sector wage increases (which appear to have benefited Scotland and Northern Ireland). See Select Committee on the Barnett Formula (2009) The Barnett Formula (HL Paper 139). House of Lords, London: The Stationery Office Limited
Policy differences following devolution

In many ways looking across the four UK countries, England is the “odd man out”: only in England is there a strong Conservative Party and significant independent sectors for health care (and schools). Both mean that the NHS in England is exceptionally subject to challenges to improve its performance. Greer has characterised the policy approaches taken in each country with emphases as follows: for England, on markets and management; for Scotland, on the medical profession and co-operation; for Wales, on localism and wider public health issues; and for Northern Ireland, on permissive managerialism -- the suspension of the Northern Ireland Assembly resulted in stasis in the development of health policy through much of the post-devolution period. Some policy differences are obvious to patients: only in Scotland is there free personal care for older people, and only in England do charges for prescriptions from GPs continue (with exemptions for the young, old, unemployed and chronic sick).

Before political devolution, each country was subject to a common policy that applied throughout the UK with latitude for minor variations in the devolved countries, which was driven by pressures on the English NHS. Unlike the SSN, the norm for the NHS is strong control of costs, so that its financial crises are those of “underfunding”. The controversial White Paper *Working for Patients*, which promulgated the policies of an internal market, was a response to a crisis of “underfunding” in the winter of 1987-88. These policies were implemented throughout the UK and created a “purchaser / provider” split, which was based on the idea that purchasers would contract with independent providers on the basis of price and quality with “money following the patient.”

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17 Harrington et al (2009) *op cit.* argue that Greer is wrong to claim that a “natural experiment” is taking place between UK countries because there is common ground in each country in seeking to reduce inequalities in health. This misses the vital distinction that governments in each country had common policy objectives (in, e.g. reducing hospital waiting times and improving the speed of responses by ambulances to life threatening emergency calls) but chose different policy instruments as the means of achieving those ends. The differences in policy instruments that Greer highlights are the subject of the natural experiment. See Harrington, B. E., Smith, K. E., Hunter, D. J., et al. (2009). Health inequalities in England, Scotland and Wales: Stakeholders’ accounts and policy compared. *Public health*, 123(1), e24-e28
20 This meant that District Health Authorities in England and Wales, Health Boards in Scotland, and Health and Social Service Boards in Northern Ireland, became “purchasers” and their hierarchical role in governing providers was replaced with contractual arrangements. Providers became “independent” NHS Trusts.
Following its election in 1997, the Blair government’s initial set of policies for the NHS in England and Wales, were described as offering a “third way” based on collaboration compared with two “failed” alternatives: the “divisive internal market system of the 1990s”, and the “old centralised command and control policies of the 1970s” (the last time there had been a Labour government). But the “third way” was hampered by a lack of resources for the NHS, which resulted in another perceived “crisis” of underfunding, which was seen as a root cause of the malaise of poor quality. On Sunday 20th January 2000, after a television interview by the Prime Minister of the UK, Tony Blair, the government made the commitment to increase spending on the NHS in the UK to the European average spend on health care as a percentage of GDP. The dramatic increases in funding of the NHS in England fed through to the devolved countries. Only in England, however, did the government, make it clear that extra funding of the NHS was to be in return for a transformation of performance. The government for England emphasised in the summer of 2000, in The NHS Plan that “investment has to be accompanied by reform” and promulgated ambitious targets for increases in capital development and staffing, reducing waiting times for access to the NHS, and improving services for cancers, coronary heart disease and the mentally ill. The NHS Plan emphasised that, for the NHS in England, there would be a new regime of performance management with a radically new system of incentives that would reward success and penalise failure. This became the regime of annual “star ratings” of NHS organisations which applied between 2001 and 2005. In this regime, failure to achieve the government’s “key targets” (dominated by waiting times for hospital or General Practitioners, and response time to life-threatening emergency calls by ambulances) would result in that organisation being “zero-rated”, publicly “named and shamed” as “failing” and the threat of the sack for the chief executive.

Another innovation of the internal market was the creation of new small scale purchasing by GPs who opted to become fundholders, of which various forms emerged over time. See Mays, N. and Dixon, J. (1996), Purchaser plurality in UK health care: is a consensus emerging and is it the right one? London: King’s Fund.


23 Secretary of State for Health (2000) op cit.

24 The commitment was to: 7,000 extra beds in hospitals and intermediate care; over 100 new hospitals by 2010 and 500 new one-stop primary care centres, over 3,000 GP premises modernised and 250 new scanners, 7,500 more consultants and 2,000 more GPs, 20,000 extra nurses and 6,500 extra therapists, 1,000 more medical school places (p. 11).

25 The commitments were that by 2004 patients will be able to have a GP appointment within 48 hours, long waits in accident and emergency departments will be ended, by the end of 2005 the maximum waiting time for an outpatient appointment will be three months and for inpatients, six months (pp. 12 - 13).

26 Secretary of State for Health (2000) op cit.
executive. This was to replace the system, which had emerged in the “third way”, which was described as one that “penalises success and rewards failure” (e.g. by bailing out hospitals with long waiting times and lists by rewarding them with extra money); and hence had inadvertently created a system of perverse incentives (p. 28). Towards the end of this period, starting in 2002/03, another internal market was gradually introduced that emphasised provider competition based on patient choice between public and private providers with a system of funding in which “money followed the patient”. From 2006 “star ratings” were succeeded by the annual “Healthcheck” which was published until 2009 but was stopped by the Coalition government. Since then the Nuffield Trust has produced a report for the Secretary of State for Health in England on the pros and cons of rating systems for providers of health and social care.

Although all governments in the UK countries introduced targets for waiting times for hospitals, and for response times to life-threatening emergency calls by ambulances; the devolved countries did not follow the English regime of “star rating”. There was no system of publishing performance with “naming and shaming”. In Wales and Scotland, those working in the NHS perceived the traditional system of perverse incentives to continue.

Auditor General for Wales (2005a), op cit, p. 16.
Bevan and Hamblin (2009) op cit.
From 2010, differences in policies have become more marked with England being even more the “odd man out”. The Coalition Government, elected in 2010, has implemented a controversial health policy for England which has taken legislative effect from 1 April 2013. This again re-organised the NHS with emphases on provider competition, and pluralism in delivery (to encourage market entry by any willing provider), in which GP-led commissioners, in the form of Clinical Commissioning Groups, are required to seek out competition. In contrast the governments in Scotland and Wales have decided to abandon the purchaser/provider split and go back to hierarchical organisations, which takes their countries’ organisational structure back to that which was in place before the introduction of the internal market across the UK in 1991. The governments in each country aim to limit the role of the private sectors so that, the NHS is essentially a monopoly supplier of health care. In Northern Ireland, although there is a commissioning body, and Trusts exist as independent providers, the review by O’Neill et al highlight an absence of pressure from competition (pp77-78). Box 1 summarises policy differences across the four NHSs.


41 O’Neill et al ibid.
### Box 1: Policy and Organisational Characteristics of the four countries of the UK

<table>
<thead>
<tr>
<th></th>
<th>England</th>
<th>Wales</th>
<th>Scotland</th>
<th>Northern Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (Millions)</td>
<td>50</td>
<td>3</td>
<td>5</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Organisational characteristics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commissioner / provider split</td>
<td>Yes</td>
<td>Abolished in 2009</td>
<td>Abolished in 2004</td>
<td>Yes</td>
</tr>
<tr>
<td>Provider markets, patient choice, pluralism in delivery &amp; providers paid by activity</td>
<td>From 2006</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Integration of health and social services</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Commitment to election for local NHS governing bodies</td>
<td>No</td>
<td>No</td>
<td>Yes (in 2007 but not yet implemented)</td>
<td>No</td>
</tr>
<tr>
<td><strong>Performance regimes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targets for waiting times</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual public reporting of performance in a system “naming and shaming”</td>
<td>From 2001 to 2009</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Charges &amp; entitlements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free personal care services for the over 65s</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Free prescriptions</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Outcomes of the UK’s Natural Experiment

One hypothesis of the outcomes of the UK’s “natural experiment” in policy differences across the UK’s four NHSs would be that the outcomes would show that “small is beautiful”\(^\text{42}\); that the performance of the three NHSs in the devolved countries would outstrip that of the NHS in England. In particular, the devolved countries of Scotland and Wales are of an optimal size for governance of health care: they are big enough to have an extensive range of health care services from basic to highly specialized, yet small enough to be well governed. A recent study\(^\text{43}\) found relatively few comparable indicators available before and after devolution to assess the outcomes of this “natural experiment” and argued that North East region of England, which has a similar socio-economic profile and health expenditure to the devolved countries, offers a sounder basis for comparison than England as a whole\(^\text{44}\). As the most recent data for this study’s comparisons were based on 2006, this is in effect a comparison of the regime of “star ratings” in England (which applied from 2000 to 2005) with the weaker systems of performance management in the devolved countries. The study found that the North East of England performed better than the devolved nations in terms of lower waiting times and higher crude productivity of hospital staff. This has been confirmed by other studies\(^\text{45, 46}\).

The impact of different arrangements for accountability

Hence, insofar as the available data allow, the outcomes of the “natural experiment” following devolution in the UK suggests that “big was beautiful”: that is that the performance in England was better in 2006 than in the devolved nations. This raises important questions in relation to the different constitutional arrangements for funding and accountability for England and the devolved countries. It looks as if the strong performance of the English NHS on waiting times, at least partly, justified its...


\(^{44}\) It is misleading to compare the devolved countries with England, because of differences in scale and the extent of variation between the English regions and the concentration of teaching and research in London.

\(^{45}\) Although no comparable data were available for waiting times for Scotland (for all three time points), Propper et al have shown that England performed significantly better than Scotland in reducing waiting times over the period 1997/98-2003/04. See Propper C, Sutton M, Whitnall C et al. (2010) Incentives and Targets in Hospital Care: Evidence from a Natural Experiment. *Journal of Public Economics*, 94(3-4): 318-335.

\(^{46}\) Sutherland and Coyle examined various dimensions of quality of care across the four NHSs and found only one systematic difference across the four nations, namely, that of lower waiting hospital times in England. They found no evidence of gains in other dimensions of quality in any of the devolved countries that could offset their poorer performance, compared with England, in terms of lower crude productivity of hospital staff and longer hospital waiting times. See Sutherland K, Coyle N. (2009) Quality in healthcare in England, Wales, Scotland, Northern Ireland: an intra-UK chart book. London: The Health Foundation.
continued large increases in expenditure. This then simply generated growth in expenditure on public services in the devolved countries which generously funded their less-well-performing NHSs, and in effect also, for example, “free” prescriptions (in all three countries), “free” social care (in Scotland) and no or lower undergraduate tuition fees (“free” in Scotland, and subsidised in Wales). In England in effect managerial accountability to the UK Treasury was accompanied by a series of policies to challenge produce capture. For the devolved nations, the accountability for performance of their NHSs was not to the UK Treasury, but to the electorates of the Parliament in Scotland, and Assemblies in Wales and Northern Ireland. Our evidence suggests that the former was more effective than the latter, and this has been confirmed by a study by Hood and Dixon. They found that the poor performance of the devolved nations as compared with England brought no political costs; and also that the policies of strong performance management in England that delivered a transformation of waiting times in England brought no political benefits. This raises two questions. First, are governments in the smaller devolved nations more vulnerable to producer capture than England’s? Second, what incentives do governments have to challenge producers to improve health services? Paradoxically, we now know that, since 2006, significant reductions in waiting times have also been achieved in Wales and Northern Ireland. A plausible explanation for this is that these devolved administrations sought to match achievements in England, suggesting that they were concerned about their reputations even if there is little sign that they would have been penalised at the ballot box.

Looking forward, the UK’s “natural experiment” in health policy offers a wonderful opportunity to evaluate policies of provider competition: the NHS in England is implementing provider competition as the main way of enabling increases in demand to be financed over a period of little if any “real” budgetary growth; and Scotland and Wales looking to various forms of service coordination and “integration” as the better way to deal with austerity, which in Wales means “real” reductions in spending on its NHS.

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Conclusions

It is seen that there is a close connection between constitutional / institutional arrangements of the two countries examined and health policy. Our analysis confirms that these do matter and that the way they have developed reflect how these relate to perceived problems and who is to be accountable for tackling them. In the two NHSs, the problems have been different and hence so have the policy responses.

In the Italian SSN, the story is of a constitutional struggle between a weak central government seeking control total costs, financed by general taxation, over 21 regions, which had autonomy over spending. Little progress was made until the centre devised a way of neutralising the constitutionally based spending power of the regions. After a lengthy process of trial and error, a battery of controls has been designed which seems effective in nudging and pushing the regions to introduce what the centre sees as virtuous policies of cost control. Regions that fail to reduce deficits face the risk of loss of control of the decision process, including spending. In the UK the story is very different. The main engine of decisions on spending on the NHSs in the four countries is the UK government’s decision on changes in spending on the NHS in England, which indicates the direction of changes for the relatively small devolved countries. From the 1980s, administrative arrangements for decisions on, and control over, spending on the NHS in England has tended to produce effective control over total costs and serious problems over its performance in terms of variations in the quality of care. The evidence so far, after 15 years of devolution, suggests that constitutional arrangements for administrative accountability of the English NHS generates policies that have been more effective in tackling problems of variations in quality, in particular long hospital waiting times than the political arrangements for accountability in the devolved countries. It may be that the explanation for that difference is that governments in the small devolved countries are more vulnerable to producer capture and hence unwilling to introduce systems in which failures in performance result in sanctions rather than rewards.
One trivial implication of the findings from these two countries, which are similar at
the national level in so many respects and in their systems of health care, is that at the
subnational level, they show profound differences. In Italy, the struggle is that for cost
control between the State and “regions in difficulty”. In England, the struggle is by
administration at the centre for improvements in quality in a system where costs are
controlled effectively; it seems that, however, devolved countries are relatively free of
such pressures from their electorates. Hence for us this comparative study has
highlighted the importance of understanding systems of accountability in the
subnational governance of health care.