National Assembly for Wales
Research paper

The organisation of the NHS in the UK: comparing structures in the four countries

May 2015

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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The organisation of the NHS in the UK: comparing structures in the four countries

May 2015

Dr Shane Doheny

This paper compares the organisation of health care systems in the United Kingdom. The paper outlines the main differences in the health care systems, paying particular attention to the organisational arrangements that operate across the UK and within each of the four countries..

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1. Introduction

Rudolf Klein **pointed out that** "Health care reform has been one of the worldwide epidemics of the 1990s". Since the 1990's, health systems in the UK have shown little immunity to reform. Indeed, following devolution, the NHS in each of the four nations has undergone at least one, if not two (in the case of England and Wales), major reforms.

2. Designing health care systems

The NHS focuses on providing care that is free at the point of delivery. Care is delivered by specialities, using resources that require maintenance, development and management. The system design shapes how specialties connect with each other and patients. At the most basic level, health care systems can either use market type levers - relying on pricing, competition and contracts - or bureaucratic levers - performance management, targets, standards and direct control. In general, health care systems differ to the extent that they use these levers:

- To the extent that co-operation, integration and team-working are important, then policy makers will press on bureaucratic levers.
- To the extent that competition, efficiency, and responsiveness to patients are important, policy makers press on market levers.

What we have seen in all four countries is a commitment to the values of integration, cooperation and collaboration that bureaucracy promotes. This lever has been of particular importance in Wales, Scotland and Northern Ireland. Only in England has there been an increased use of market levers.

This use of levers relates both to the design of the system, and to how the elements interact. In a purely bureaucratic system, power flows down the system and service providers account for their work to intermediaries and ultimately to the government Minister in charge. A market system separates service providers into entities offering services in a market, and competing for customers based on quality and price. So whereas in a bureaucracy, providers are made accountable to the Minister through managers, a market encourages providers to be more accountable to patients.

England

In 1991, the Conservative administration introduced reforms that separated NHS organisations into purchasers and providers of health care. The New Labour government (1997-2010) refined these market levers when it **introduced** reforms to provide ‘maximum devolution of power to local doctors and other health professionals’. This was to be achieved by mixing market levers with a renewed focus on quality standards. In 2010 the Conservative/Liberal Democrat Coalition government was again devolving power away from Ministers, drawing on values of fairness and solidarity.

Critiquing the 'piecemeal' development of NHS structures, the **Coalition** sought to ‘establish more autonomous NHS institutions, with greater freedoms, clear duties, and transparency in their responsibilities to patients and their accountabilities’. Power was devolved to place control with professionals and patients. The objective was a system in which ‘organisations enjoy greater freedom and clearer incentives to flourish, but also know the consequences of failing the patients they

serve and the taxpayers who fund them'. This was achieved by relinquishing some bureaucratic levers, and enhancing market levers.

Northern Ireland

Health and Social Care (HSC) in Northern Ireland was reorganised following **the Review of Public Administration**. The first major change to occur was the merger of 18 HSC Trusts into five geographic HSC Trusts, and a single ambulance service Trust.

The administration of HSC has since been reorganised by the **Health and Social Care (Reform) Act 2009**. The Act created a system that mixes bureaucratic with market levers. According to the **explanatory memorandum** attached to the Health and Social Care (Reform) Bill, the objective was to put in 'place structures which are patient-led, patient-centred and responsive to the needs of patients, clients and carers as well as being more effective and efficient (releasing resources for investment in front line health and social care).'

The importance of co-operation is underlined by the Department's 'duty to promote an integrated system of health and social care designed to secure improvement in the physical and mental health and social well-being of people in Northern Ireland'. A HSC Board is responsible for commissioning services and so market levers are retained. The Board identifies need through five Committees of the Board known as Local Commissioning Groups that assist the Board to purchase care from Trusts on behalf of their resident populations. This system combines a top down bureaucracy associated with targets, integration, co-operation, with market levers associated with purchasers and providers of health care.

Scotland

The National Health Service Reform (Scotland) Bill was introduced by the Labour-Liberal Democrat Coalition Scottish Executive in 2003. The Bill sought to abolish NHS Trusts further **dismantling the internal market** in the NHS in Scotland and '**integrating** the management of acute and primary care services into NHS Boards'. This Bill was **passed into law** in 2004. Market levers were to be removed from the NHS and more bureaucratic levers introduced. The Act increased the powers of the Minister to intervene in failing organisations, introduced a duty of co-operation on Health Boards and allowed for 'greater involvement of the public in service planning'. In 2014, **the Public Bodies (Joint Working) (Scotland) Act** was passed into law, further cementing co-operation, collaboration and control as the central pillars of this system.

Wales

In 2009, a minority Welsh Labour Government replaced a system that mixed market and bureaucratic levers in the NHS, with a new system that removed most market levers. The objective of these reforms was to focus on patient care, and **to develop** a 'structure [that] will provide a simpler and more transparent decision-making process that will benefit patients and staff'. These reforms were:

> [...] about developing a service which is based on co-operation, collaboration and partnership working. It is not based on market concepts and is value driven. It means a shift in the balance of care, looking at whole systems rather than just hospitals. There is a strong emphasis on public health and long-term planning

Edwina Hart, then the Minister for Health and Social Services, maintained that the removal of market levers provides space for the NHS to focus on planning, co-operation, collaboration and encouraged people to think about 'whole systems rather than just hospitals'.

3. Deciding on the shape of the NHS

The organisation of the NHS in each of the four countries is driven by political and systemic considerations. The **Institute for Government** identifies three main influences on a decision to change departmental structures:

- **External challenges:** the growth of new demands and priorities that the department has to deal with
- **Administrative challenges:** the performance of the existing department
- **Political and cabinet considerations:** the need for political leaders to work with the interests and talents offered by senior colleagues

Decisions on how to organise the NHS therefore involve resolving external, administrative and political challenges. The **Northern Ireland Assembly Research Service** draws on work by **KPMG** that further divides these influences:

Drivers of government department reorganisation

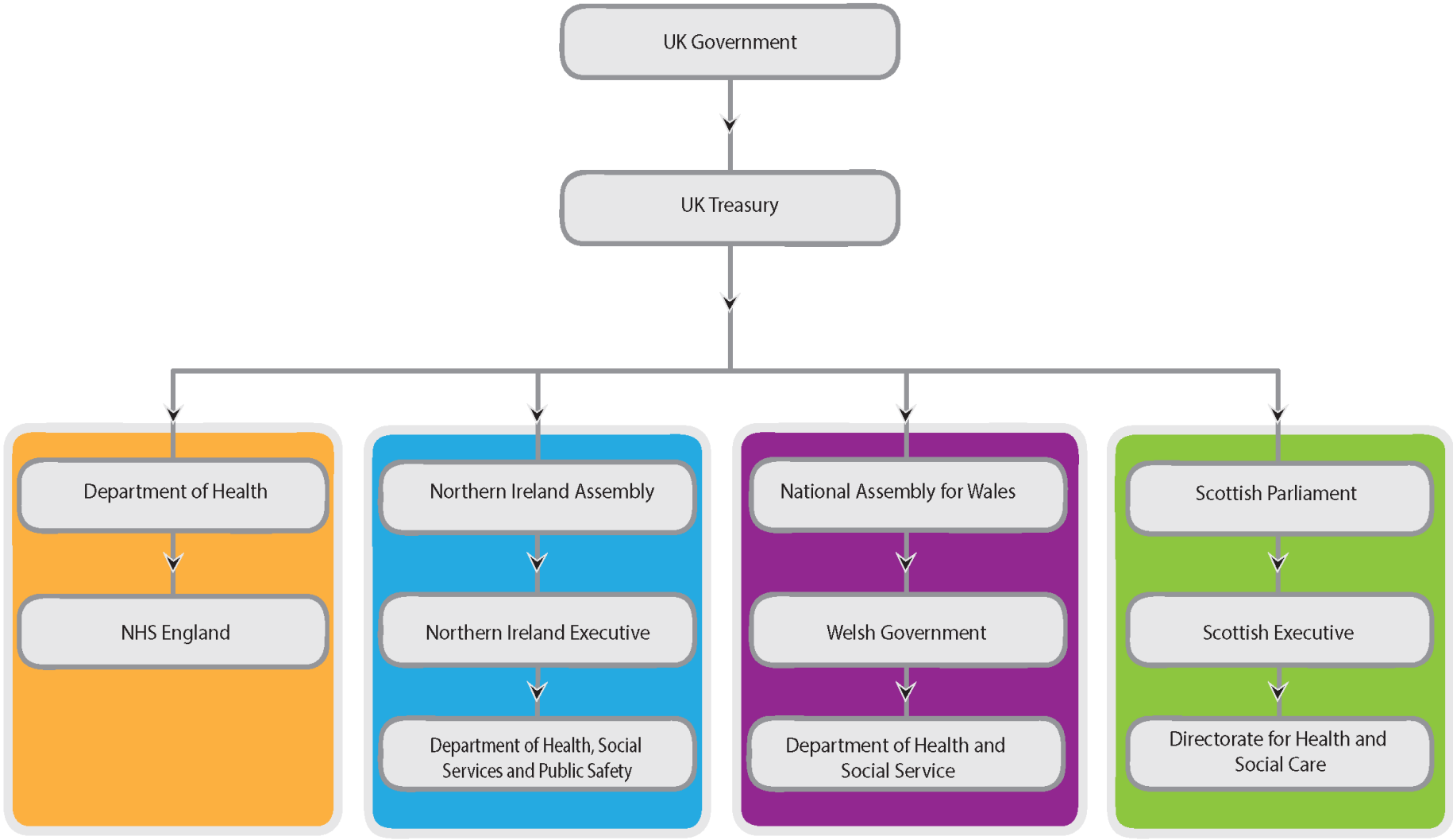
External	Clearer focus on areas of priority	Respond to emerging problems Disinvest from some areas
	Greater coordination between policy areas	Pooled budgets Policy networks Cross cutting working groups
Administrative	Need to achieve efficiencies	Ration resources Combine services or roles Centralise services
	Tackle underperformance	Address management Merge or abolish departments
Political	Achieve political objectives	Cabinet structure Manifesto commitments

The decision to organise the NHS either as a market or a hierarchy has to do with resolving these challenges. The decision may be driven by political manifesto commitments and the desire of cabinet members to use the levers of the market or of bureaucracy in order to achieve these objectives. The operational structure then needs to address emerging issues, and to be flexible enough to withdraw services for areas that are no longer a priority, or where the service is ineffective. This operational structure also needs to address administrative challenges. The reasons for reorganising the NHS may be driven by any one or more of these factors.

Allocating funding to the NHS

The NHS in each of the four countries is composed of a complex network of organisations. The systems are composed of organisations that deliver, monitor, improve and commission services. The departments charged with organising health care delivery in the devolved administrations each receive their resource allocation from their respective governments. Whereas the UK Department of Health receives funding directly from the Treasury based on the funding priorities of the UK Government, the Treasury also sets the Departmental Expenditure Limit for each devolved administration. It is up to each devolved administration to allocate resources to fund services under their control. These administrations can decide how much of their allocated resources to divert to healthcare. The Scottish Executive has certain additional tax raising powers, and so can make its own adjustments to its overall funding envelope.

Allocation of funding to health care departments in the UK



4. The Health Service across the UK

A UK NHS

The UK **Department of Health** receives its funding directly from the Treasury, and has certain UK wide health care responsibilities in **emergencies** (for instance, in planning an influenza pandemic response). The UK **Secretary of State for Health** has a duty to promote a comprehensive health service in England and has **responsibilities** for the work of the UK Department of Health. While health policy has been devolved, the UK Government retains power on certain issues.

Devolution of health policy powers

	Northern Ireland	Wales	Scotland
Devolved	Health and social services	Health and health services	Health and social work
Non-devolved	Human genetics, human fertilisation, human embryology, surrogacy arrangements. Xenotransplantation. Vaccine damage payments.	Abortion. Human genetics, human fertilisation, human embryology, surrogacy arrangements. Xenotransplantation. Regulation of health professionals (including persons dispensing hearing aids). Poisons. Misuse of and dealing in drugs. Human medicines and medicinal products, including authorisations for use and regulation of prices. Standards for, and testing of, biological substances (that is, substances the purity or potency of which cannot be adequately tested by chemical means). Vaccine damage payments. Welfare foods.	Abortion. Xenotransplantation. Embryology, surrogacy and genetics Medicines, medical supplies and poisons. Welfare foods. **Misuse of and dealing in drugs**.

The Department of Health manages its direct UK wide responsibilities through the **Medicines and Healthcare Products Regulatory Agency**, **Professional Standards Authority for Health and Social Care**, **Human Fertilisation and Embryology Authority** and the **Human Tissue Agency**. Welfare foods are regulated by the **Food Standards Agency**, a non-departmental agency. The Department of Health also operates advisory committees. These include **National Institute for Health and Care Excellence** (NICE) (a non-executive Government department) and the **Joint Committee on Vaccination and Immunisation** (JCVI).

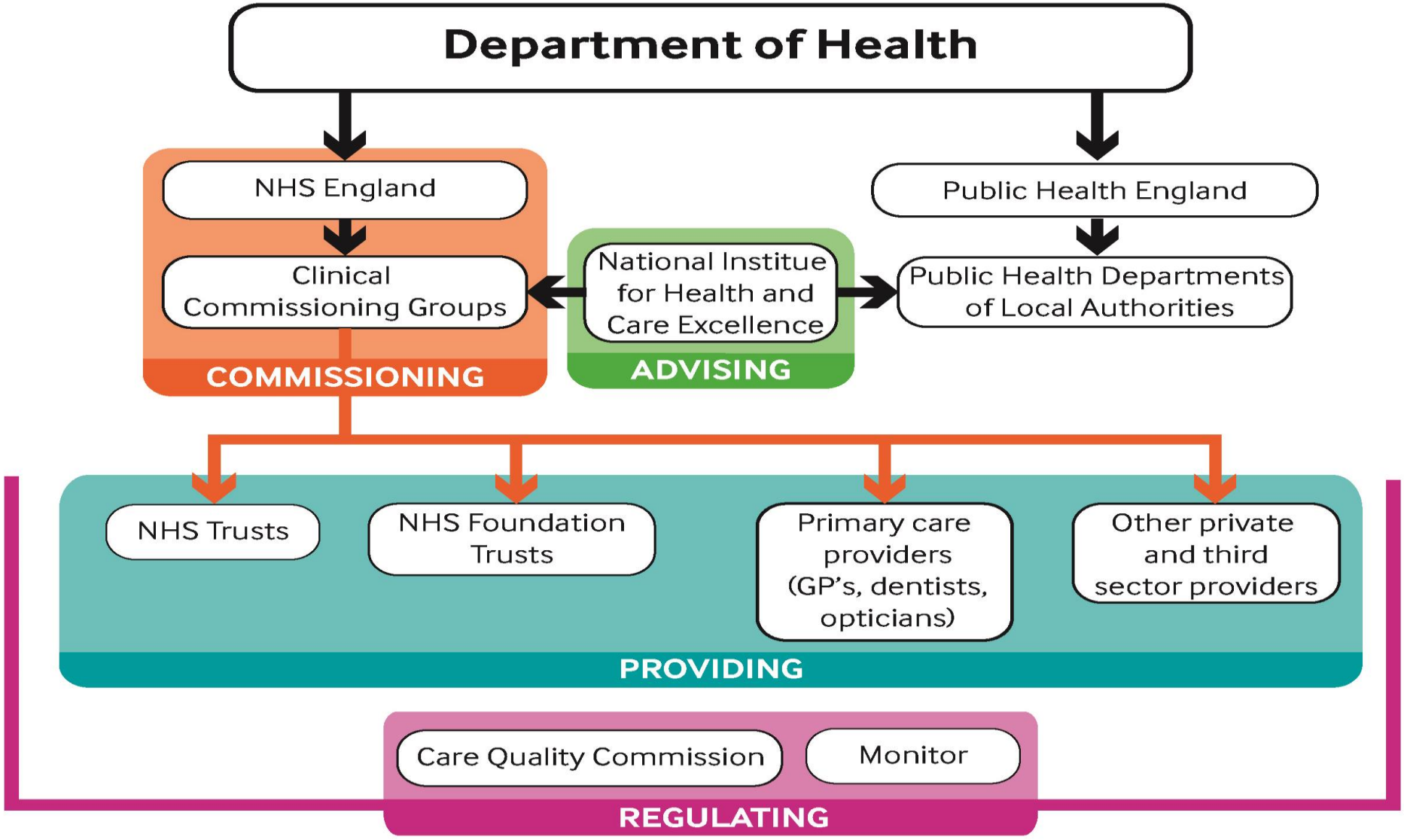
UK wide responsibilities of the Department of Health

NHS England

In England, the NHS is structured along the lines of an internal market. This means there is a separation between the purchaser and the provider of care, and business or market practices are part of how NHS organisations work. In **Equity and Excellence: Liberating the NHS**, the UK Conservative/Liberal Democrat Coalition Government criticised the powers of the UK Secretary of State for Health to 'micromanage parts of the NHS' and the use of layers of management. The Coalition proposed moving away from the use of bureaucratic power and expanding market levers by making NHS institutions more autonomous. Control was to be devolved from the Secretary of State and NHS managers, to professionals and patients. These changes were driven by a critique of the administration and management of the NHS, combined with a belief that the solution lay with greater freedom for professionals and organisations. These professionals and organisations would be made free by the extension of market mechanisms in the NHS.

Under its **current arrangements**, the UK Department of Health has an overall responsibility for healthcare provision in the UK, and specific responsibility for organising the NHS in England. The work of this department is mostly scrutinised by the House of Commons' **Health Committee**. In relation to the NHS in England, the Department of Health retains its responsibility for overall stewardship of the system, but manages the NHS using **Arms Length Bodies** (ALBs). This means that the Department of Health is not directly involved in operational matters and relies on ALBs who commission and regulate care

Structure of the NHS in England



Overall responsibility for commissioning healthcare in England lies with the Department of Health's largest ALB, **NHS England**. NHS England is responsible for allocating funding to 211 Clinical Commissioning Groups (CCGs), and for holding CCGs to account. NHS England also commissions some services itself **including** specialised services, primary care, offender healthcare and some services for the armed forces. CCGs in turn, commission NHS Trusts, NHS Foundation Trusts and primary care providers. The **National Institute for Health and Care Excellence** provides advice and guidance to Clinical Commissioning Groups and to local authorities in England.

Regulation of the NHS in England is carried out by **Monitor** and the **Care Quality Commission**. Monitor regulates the health services in England. As sector regulator, '**Monitor's** main duty is to protect and promote the interests of NHS patients'. Hence, Monitor has responsibilities for setting prices for NHS-funded services, and helping commissioners make sure that essential local services for patients continue if providers get into serious difficulty. The Care Quality Commission monitors, inspects and regulates the quality and safety of services provided by all health and social care providers in England. In this role, the **Care Quality Commission** checks that the people of England get good quality care from hospitals, dentists, ambulances, care homes and services that support people at home and ensures that people who need extra help to stay safe, get good care.

In England, the Department for Health is sets policies on public health. **Public Health England's** role is to provide **leadership and advice** to support public health, and to work with the NHS and local authorities to implement public health policies.

HSC Northern Ireland

In Northern Ireland, health and social care is structured in a way that combines market and bureaucratic levers. This means that the Northern Ireland Executive, through the Minister for Health, Social Services and Public Safety retains control over the NHS using bureaucratic levers. But NHS organisations also have some freedom to offer and commission services in a market. This arrangement was **introduced** to cope with external changes – the changing demands and expectations of a changing population – and with an interest in making the NHS more **efficient and patient centred**.

The Department of Health, Social Services and Public Safety has primary responsibility for operating the system in Northern Ireland, for holding health care bodies to account and for commissioning and delivering care. The department delegates these responsibilities to a number of subordinate bodies. The Department itself is responsible to the **Minister for Health, Social Services and**

Public Safety who is a member of the Executive Committee of the Northern Ireland Assembly, and whose work is scrutinised mainly by the Committee for Health, Social Services and Public Safety.

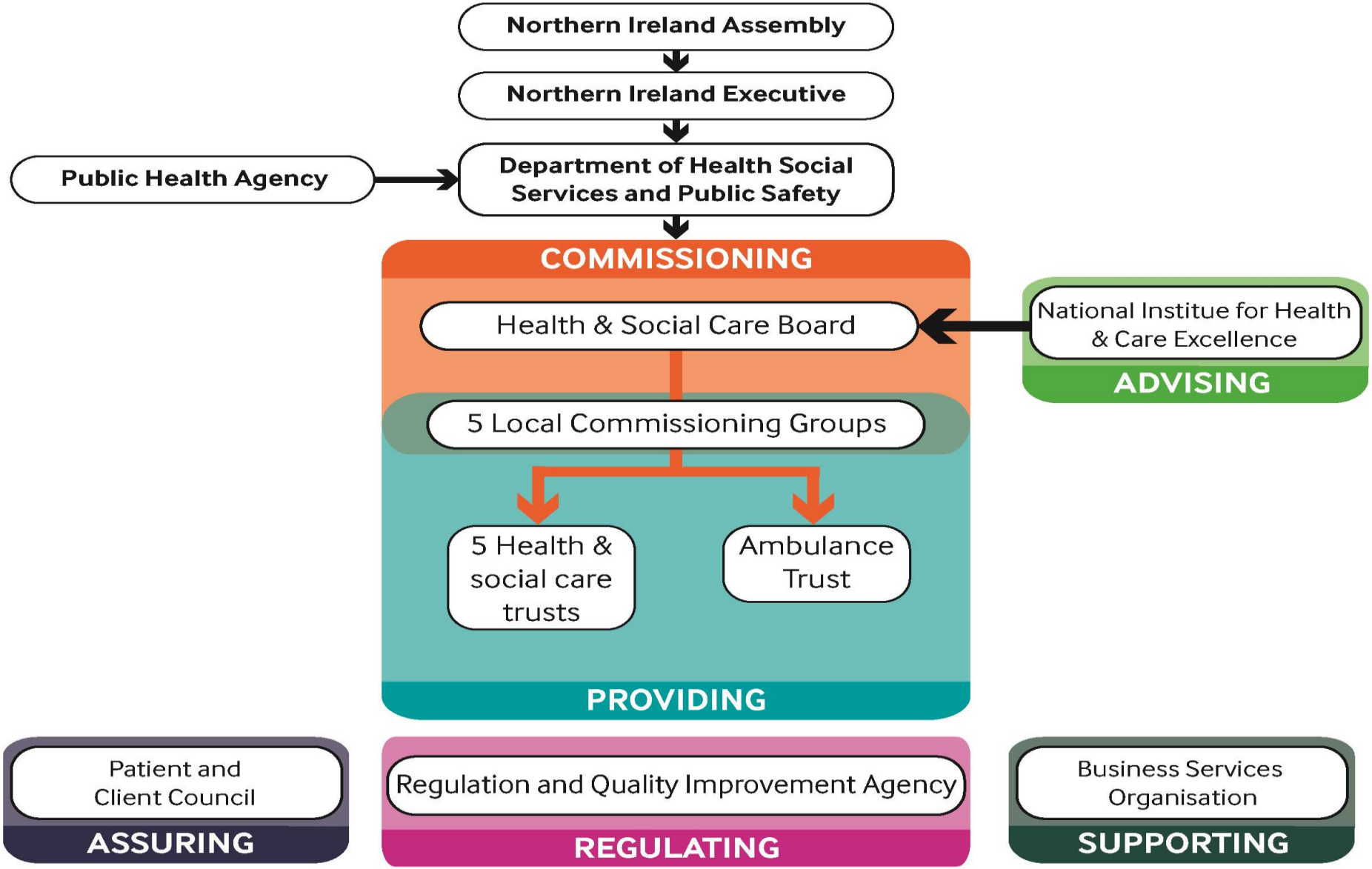
Responsibility for commissioning care and managing performance is delegated to the Health and Social Care Board (HSCB). The HSCB commissions care and manages the performance of five geographic Health and Social Care (HSC) Trusts and one Trust that operates across Northern Ireland (the Northern Ireland Ambulance Service).

The HSCB receives assistance in its work with Trusts from five Local Commissioning Groups (LCGs). These groups cover the same area as their respective HSC Trust areas. LCGs are expected to assess local health and social care needs, to plan how to meet needs, and to secure the delivery of care suited to needs. Trusts, LCGs and other health and care organisations receive support from the Business Services Organisation (BSO). The BSO provides support on a range of services including financial and procurement services, legal services, personnel and information technology. Finally, the Patient and Client Council (PCC) is a regional body supported by five local offices which again cover the same area as Trusts and LCGs. The PCC's role is to provide a voice for patients, clients, carers, and communities on health and social care issues. Thus, at the centre of this system, the HSCB commissions services from Trusts with the support of LCGs. These organisations are supported by the BSO, and the PCC.

Public health in Northern Ireland is the responsibility of the Public Health Agency. This Agency is responsible for improving health and social well-being, health protection and service development. Regulation is carried out by the Regulation and Quality Improvement Authority (RQIA). The RQIA's 'role is to ensure that health and social care services in Northern Ireland are accessible, well managed and meet the required standards'. The NHS in Northern Ireland takes the advice of the NICE, while the RQIA provide assurance that NICE guidance is implemented. Outside of these are a number of other organisations (Agencies and Non Departmental Public Bodies) with various roles. These organisations include:

- Northern Ireland Guardian Ad Litem Agency
- Northern Ireland Blood Transfusion Service
- Northern Ireland Social Care Council
- Northern Ireland Practice and Education Council for Nursing and Midwifery
- Northern Ireland Medical and Dental Training Agency

Structure of the healthcare system in Northern Ireland



Among the key features of the 2009 reforms of the administration of the health care system in Northern Ireland was how public health was placed at the **centre of the new system**. The **Public Health Agency** is primarily responsibility for public health in Northern Ireland. Alongside specific tasks, this agency also has a responsibility to promote **partnerships** among healthcare, local authority and voluntary and community organisations in Northern Ireland.

The healthcare system in Northern Ireland has been the subject of a recent **review** (led by Sir Liam Donaldson), and a **consultation** has been launched on the recommendations contained in this review. Recommendation 2 of this **review** holds that 'the commissioning system in Northern Ireland should be redesigned to make it simpler and more capable of reshaping services for the future'. The proposal is that a new system would either use more market or bureaucratic levers. In its current form, the NHS in Northern Ireland uses a mix of market and hierarchical levers. The argument raised by the review of the healthcare system in Northern Ireland is that this system does not make enough use of market levers to gain the benefits of competition and efficiency associated with this lever.

NHS Scotland

Although market levers were introduced into the NHS in the 1990s, there was a more reluctant uptake of these levers in Scotland. Following devolution, the Scottish Executive unified health boards and NHS Trusts. The system **was introduced** in 2004 under the Labour/Liberal Democrat coalition and maintained by the Scottish National Party when they came to power in 2007. This system has since been criticised for not doing enough to **tackle inequalities or to prioritise prevention**. The Scottish Executive has therefore **been arguing** that:

> Separate – and sometimes disjointed – systems of health and social care can no longer adequately meet the needs and expectations of increasing numbers of people who are living into older age, often with multiple, complex, long-term conditions, and who need joined-up, integrated services

These criticisms were both about the management of healthcare and the changeing needs of the population. This led to calls both to achieve efficiencies in healthcare, and to increase coordination between policy areas.

The current system in Scotland makes extensive use of bureaucratic levers such as **performance targets and standards**. The 2004 reforms of NHS Scotland were **driven** by population changes, changes in sources of support for the sick and frail, and changing patters of ill-health and mortality. Alongside these external drivers, reforms of NHS Scotland were informed by increasing trends in emergency admissions to hospitals. The **2014 reforms focus on** standardising quality, improving efficiency and integration.

As a result of the **Public Bodies (Joint Working) (Scotland) Act 2014, Community Health Partnerships** are to be abolished. In their place, Health

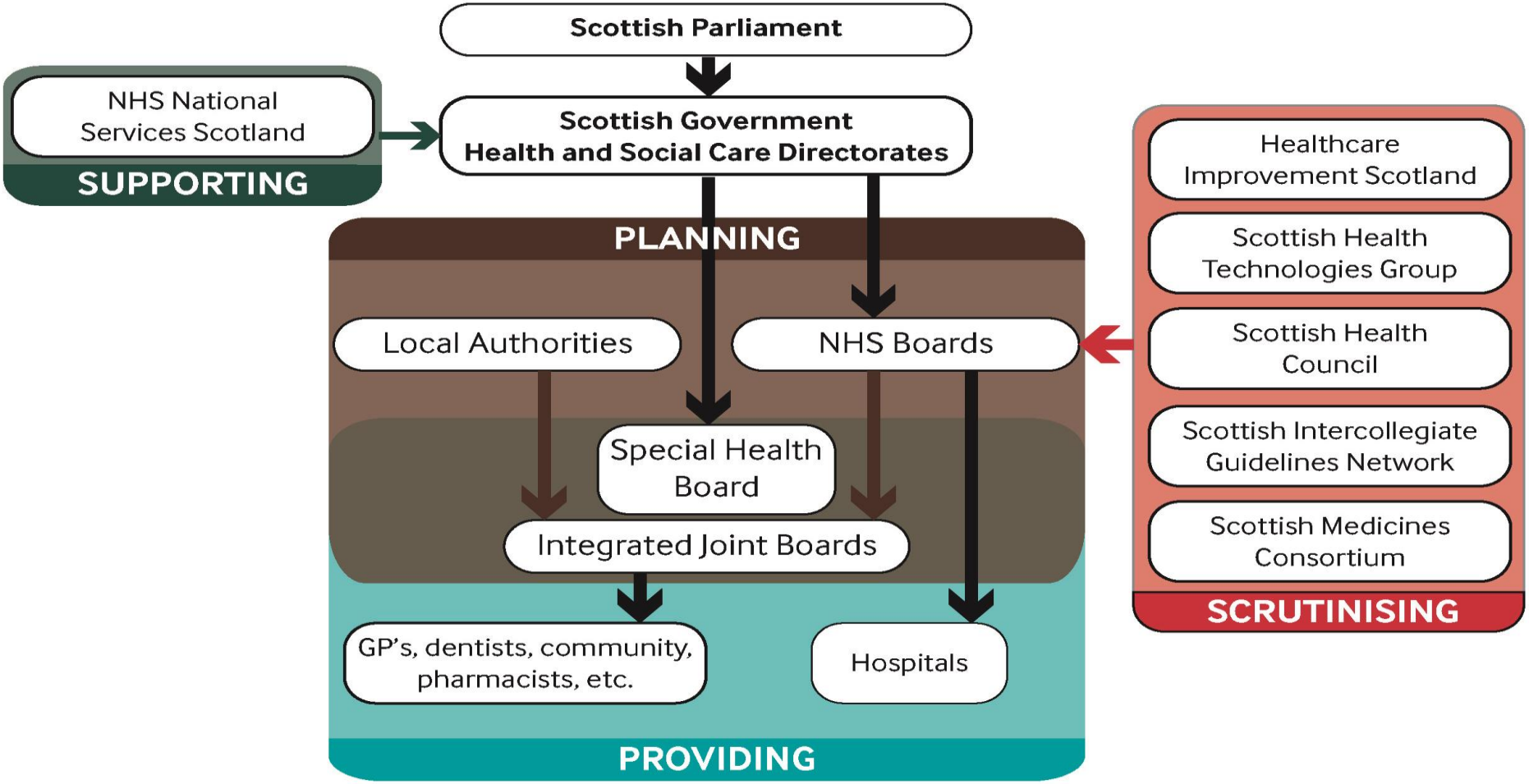
Boards and Local Authorities are to **form one of two arrangements** to **progress integration**. Health Boards and Local Authorities are either expected to delegate the responsibility for planning and resourcing service provision for adult health and social care services to form Integration Joint Boards. Or they are to decide which of them will take 'lead responsibility for planning, resourcing and delivering integrated adult health and social care services'.

The Scottish Government's **Health and Social Care Directorate** is tasked with helping people sustain and improve their health. The Directorate delegates responsibility for healthcare to **14 NHS Boards** operating in geographically defined areas. In addition, the Directorate delegates certain responsibilities to seven Special Health Boards and to **NHS National Services Scotland**, a body that provides advice and support services to the NHS Scotland. The seven Special Health Boards include:

- **NHS Education Scotland**
- **NHS Health Scotland**
- **NHS National Waiting Times Centre**
- **NHS24**
- **Scottish Ambulance Service**
- **The State Hospitals Board for Scotland**
- **Healthcare Improvement Scotland**

Healthcare Improvement Scotland incorporates organisations (**Scottish Health Technologies Group**, **Scottish Intercollegiate Guidelines Network** and **Scottish Medicines Consortium**) that issue advice to other NHS organisations and one (**Scottish Health Council**) that is responsible for agreeing the overall strategic direction of the NHS. The NHS in Scotland does recognise the guidance of the NICE, but also takes advice issued by the organisations contained in Healthcare Improvement Scotland. Similiarly, **NHS National Services Scotland** is composed of a number of health support and business support services. The NHS Boards are responsible for protecting and improving their population's health and for delivering frontline healthcare services. The role of the Special Health Boards and **Healthcare Improvement Scotland** is to support the NHS Boards by providing a range of specialist services.

Structure of the NHS in Scotland



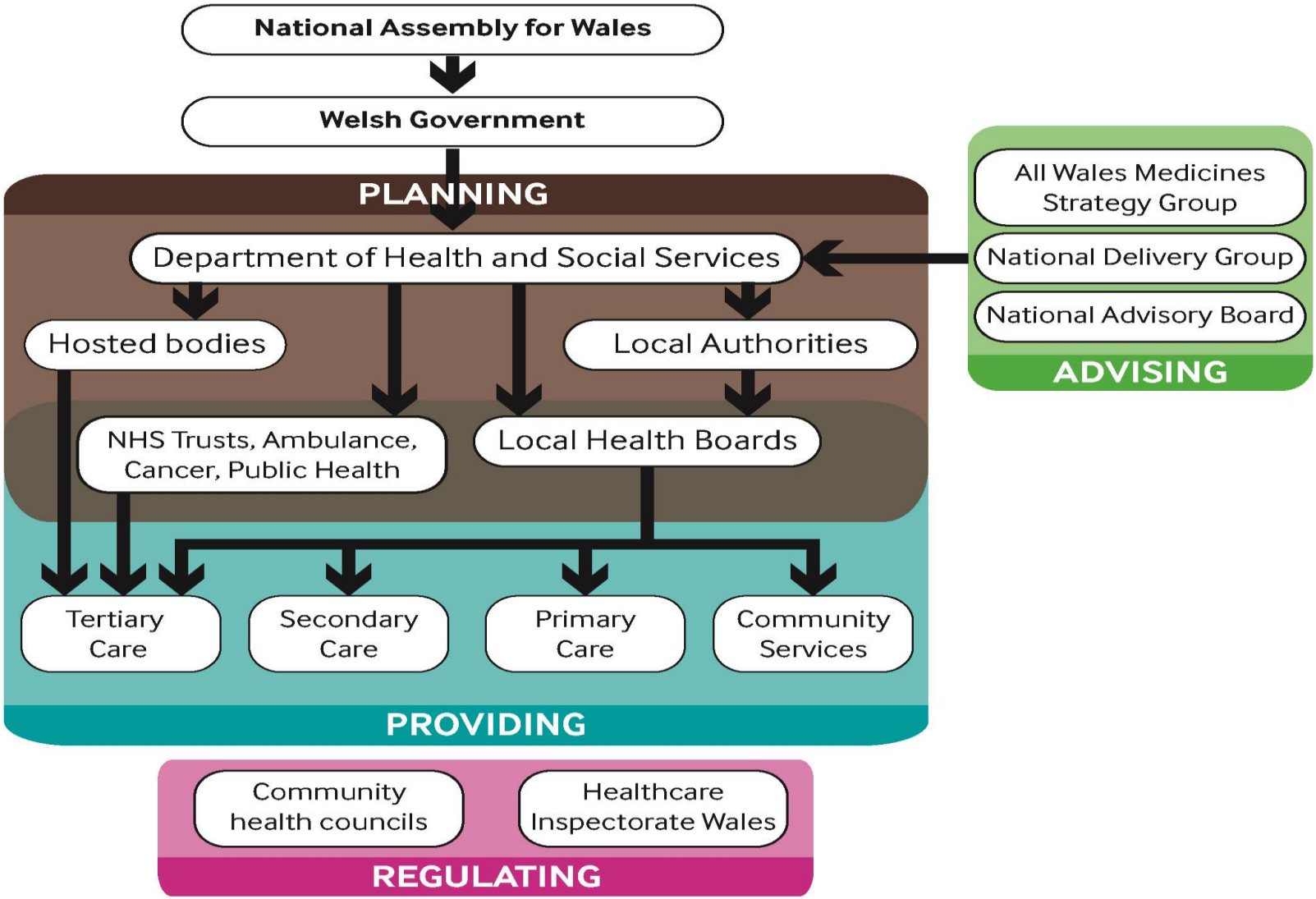
In Scotland, the Directorate for Health and Social Care **is responsible** for health policy, the administration of the NHS, community care and has some responsibility for social work. Under the new arrangements, 13 NHS Boards and 31 local authorities decide which health and social care services are to be integrated. Funding will then be devolved to the joint boards and these boards will be tasked with developing strategic plans to deliver these services. The joint boards will be accountable to both boards and local authorities. There is, however, an exception. One local authority and NHS Board **(NHS Highland and Highland Council)** have opted for the lead agency model NHS Highland is now responsible for adult health and social care services and Highland Council is responsible for children's services. The **Cabinet Secretary for Health, Wellbeing and Sport** has primary responsibility for health care, and is supported by the **Minister for Public Health** and the **Minister for Sport, Health Improvement and Mental Health**. The Cabinet Secretary and Ministers are members of the **Scottish Executive**, and their work is mainly scrutinised by the **Health and Sport Committee**. Responsibility for public health is shared between the Scottish Executive, local authorities and the NHS. The **Chief Medical Officer** takes the **national lead** on public health.

Under the system introduced by the **Public Bodies (Joint Working) (Scotland) Act 2014**, the Scottish Government will introduce health and wellbeing outcomes that ensure Health Boards and local authorities are jointly accountable for planning and delivering integrated services. The work of the Joint Boards will be driven by this outcomes framework. In so doing, the NHS in Scotland uses planning for outcomes as bureaucratic levers that can direct the work of the NHS. As the **Health and Sport Committee** notes, this framework may cement joint partnerships while recognising the role of local organisations.

NHS Wales

In Wales, the **Minister for Health and Social Services** is directly responsible for the delivery of health services. For the most part, the Minister's work is scrutinised by the National Assembly for Wales's **Health and Social Care** Committee. Other National Assembly for Wales committees also scrutinise the work of this Minister. At the centre of the health system are seven Local Health Boards (LHBs) and three NHS Trusts. These plan and provide health services for their resident population within a policy framework set out by the Minister.

Structure of the NHS in Wales



The focus on planning in Wales means that this system uses targets and plans to set out the direction of travel for the system, combined with checks and balances shaping how care is delivered. First, the Welsh Government through the Department of Health and Social Services, sets out its expectations for the NHS over various timelines. NHS Trusts and Local Health Boards (LHBs) respond to these expectations through their planning documents (mainly the three year Integrated Medium Term Plan).

Therefore, at the core of this system is a planning process that centres on a conversation between the Welsh Government and NHS bodies on how resources will be used to address healthcare needs over a three year time period. Trusts and LHBs then focus on delivering care in light of these targets. Both the Department of Health and Social Services, and LHBs and NHS Trusts receive advice and support in their respective planning roles. The Department of Health and Social Services **receives advice** from the **National Advisory Board**, while the National Advisory Group provides advice on developing and delivering policy. The **Bevan Commission** also provides advice, but this commission is not a formal part of the NHS is Wales. In addition to accepting the guidance of NICE, the NHS in Wales also takes advice from the **All Wales Medicines Strategy Group**.

LHBs engage with local authorities to decide how services are to be delivered locally. Thus, while the Minister sets the overall policy context in which LHBs and NHS Trusts operate in Wales, this policy direction is implemented using plans devised locally between LHBs and Local Authorities (Single Integrated Plans).

Since the 2009 reforms, boards of each of the seven LHBs are appointed by, and accountable to, the Minister. There are three NHS Trusts that have a specialist and all-Wales function. In addition, there are a number of hosted bodies. Each of these was set up in different ways. Although legally part of the host organisation, they exist outside of the usual management structures of their host. Hosted bodies include:

- **Welsh Health Specialised Services Committee,**
- **Emergency Ambulance Services Committee,**
- **NHS Wales Shared Services Partnership,**
- **NHS Wales Informatics Service,**
- **National Specialist Advisory Group for Cancer,**
- **National Collaborating Centre for Cancer,**
- **National Institute for Social Care and Health Research Clinical Research Centre,**
- **NHS Centre for Equality and Human Rights.**

The Wales Health Specialised Services Committee provides a service that remains the legal duty of Local Health Boards to carry out while other bodies support particular functions best discharged at a national level.

NHS Wales is regulated and inspected by Community Health Councils (CHCs) and Healthcare Inspectorate Wales. **Community Health Councils** provide 'the link between those that plan and deliver the service and those that use the service' providing an avenue of communication between managers and the public. CHCs are also empowered to inspect NHS premises. **Healthcare Inspectorate Wales** have powers to inspect both NHS providers and independent healthcare organisations in Wales. Responsibility for public health is shared among all NHS bodies in Wales, with leadership provided by **Public Health Wales**.

5. Learning from difference

Devolution has been seen as a **'changing natural experiment'** as the systems of governance started as broadly similar, but have since diverged to some extent. Clearly, there has been a divergence between systems leaning more heavily on bureaucracy, and the system in England, which draws more on market levers. The **Political Studies Association** observes:

> In theory, the main advantage of federalised systems is the opportunity to test different solutions for similar problems. At present, the NHS in England, Scotland, Wales and Northern Ireland are justifiably celebrating their autonomy, but a lack of willingness to learn from each other may deprive them of a unique opportunity to develop positive change for the NHS as a whole