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BMJ 1999;318;1195-1198

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Education and debate

Devolution and health: challenges for Scotland and Wales

Allyson M Pollock

On 6 May Scotland and Wales will elect their new assemblies. Will they have sufficient powers and sufficient finance to reverse the existing and widening inequalities in health in the United Kingdom? Will they adopt new approaches to health policy and a new focus on public health?

The structure of the new assemblies and their powers

The Scottish parliament will serve a population of five million and have a Scottish executive of about 10 ministers headed by a first minister. Its departments will include health; education and training; local government, social work, and housing; economic development and transport; the law and home affairs; the environment; agriculture and fisheries; sports and art; and research and statistics (see box). The UK parliament will retain control over the constitution, foreign policy and defence, social security, employment, and the fiscal economic and monetary system. The Scottish parliament will hold fixed term elections every four years and have 129 members, 73 elected from single member constituencies plus 56 additional members to provide proportionality.

The Welsh assembly will serve a population of about three million people and have 60 members directly elected every four years. It will assume the powers and functions currently exercised by the Secretary of State for Wales (see box). Unlike in Scotland, all primary legislation for Wales will continue to be made in parliament at Westminster.

Inequalities in health and wealth

Devolution in the United Kingdom is to a large extent a response to long term inequalities in the kingdom.

The recent 1999 Treasury report on poverty shows that, although the United Kingdom has experienced increased economic prosperity, the benefits have been unevenly distributed across the population.¹ Between 1961 and 1990 the proportion of households living in poverty (defined as less than half the average income after housing costs) doubled despite an average annual growth in UK gross domestic product (GDP) of 2.4%. Wales has experienced economic decline, with gross domestic product per capita falling from 88% of the average in 1971 to 83% in 1997.² Scotland's gross domestic product per capita has moved closer to the UK average but is still lower. A greater proportion of the Scottish population live in poverty compared with

Summary points

The new assemblies for Scotland and Wales face major challenges tackling socioeconomic and health inequalities

Primary legislation for Wales will be made in Westminster. Scotland will have primary legislative powers over the departments it controls

The new assemblies will be financially dependant on Westminster through the Scottish and Welsh "blocks." Planned changes in expenditure for England are allocated to Scotland and Wales through the Barnett formula, a population based formula rather than a needs based formula

Wales will have no tax varying powers. Scotland will have the power to vary income tax by 3p in the pound, the so called "tartan tax"

The challenge for the United Kingdom is how to improve inequalities in health and wealth and preserve equity in funding through the devolved assemblies

that of England and Wales. Only 6% of its population live at the level of affluence that is attained by 22% of the population in England and Wales and 18% of the population in Scotland is living at a level of deprivation (as measured by car ownership, social class, unemployment, and overcrowding) that is experienced by only 4% in England and Wales.³ Table 1 shows key indicators of the ways in which Scottish and Welsh populations fare worse than those in England.⁴

Just as aggregate measures of prosperity conceal social and geographic inequalities in wealth and income over time, so too do aggregate measures of health. There have been major improvements in health in terms of mortality and life expectancy at all ages in all three countries,⁵ but these benefits are not spread evenly across the population. Death rates at all ages are still higher in Scotland and Wales than in England.⁶ Standardised mortality ratios for all causes of death are 12% higher in Scotland than in England for people aged over 65 and 22% higher for people aged 0-65. Scotland and Wales also have higher death rates from lung, breast, and cervical cancer than does England (table 1).

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BMJ 1999;318:1195-8

Powers of the new Scottish and Welsh assemblies and those retained by Westminster

Scotland

- Health
- Education and training
- Local government, social work, and housing
- Economic development and transport
- Law and home affairs
- Environment
- Agriculture, fisheries, and forestry
- Sports and arts
- Research and statistics

Wales

- Health
- Education and training
- Local government, social work, and housing
- Economic development and transport
- Environment
- Agriculture, fisheries, and forestry
- Sports and arts

Westminster

- UK constitution
- UK defence and national security
- UK fiscal economic and monetary system
- Common markets for UK goods and services
- Employment legislation
- Social security
- Transport safety and regulation
- Primary legislation for Wales

Life expectancy and mortality have improved in all social classes, but the greatest reductions in mortality have been in the higher social classes. In 1970-2 there was an almost twofold difference in mortality between social classes I and V in England and Wales, but by 1991-3 this had widened to an almost threefold difference. In Scotland, from 1951 until 1971, the mortality differentials between social classes were narrower than those in England. They are now wider.⁷

Income plays an important part in determining life chances and life expectancy; welfare reforms tend to aim at getting people back to work. But a substantial number of poor people are children and older retired people. Poor people depend on cash benefits and publicly provided services. The indexing of benefits to prices rather than national earnings has eroded the relative position of poor people, and this has been aggravated by policies over the past 20 years that have raised a greater proportion of total taxation through regressive taxes on consumption such as value added

tax (VAT).⁸ The state pension is still the mainstay of most older people's incomes, accounting for 65% of older men's and 80% of older women's incomes: its value fell from 20% of national earnings in 1980 to 14% in 1993. This has also been accompanied by the erosion of other benefits such as health and social care and the introduction of charges and means testing for services, including some such as long term care that were free at the point of delivery.⁹ Moreover, between 1992-3 and 1997-8 local authorities experienced a 6% decrease in budget allocations from central government.¹⁰ As a consequence, the number of households receiving home help and the number of people receiving meals on wheels fell by 12.5% and 17.6% respectively between 1994 and 1997.¹¹ Thus the recipients of such services, who are generally among the poorest, have been hit in four different ways: cuts in financial benefits, increased indirect taxation, cuts in services, and charges for services.

Public health and devolution

Fiscal policy—keeping the assemblies in line

In Scotland the Liberal Democrats and the Scottish National Party (SNP) have pledged to forego the recently announced 1p reduction in income tax in order to target more money on education, employment, and health. The SNP has also undertaken to abolish charges for social and long term care and to abolish student fees and restore grants, while the Liberal Democrats will review charges for social and long term care and abolish charges for all eye tests and dental checks.

Neither party can propose substantial increases in public spending because Westminster will retain control over fiscal policy and public expenditure in Scotland and Wales. The Welsh and Northern Ireland assemblies will have no power to vary revenue, while the Scottish parliament will have the power to vary the basic rate of income tax by up to 3p in the pound—commonly referred to as the “tartan tax.” Exercising this option would yield, at most, some £690m extra, which represents about 4% of the total Scottish budget (currently nearly £16bn).

It will be for the new Scottish and Welsh governments to decide the distribution of the total budget between the departments, although pensions and social security will remain outside their control. Of the £16bn Scottish budget, £4.6bn is spent on health. Wales receives £7bn annually, of which £2.8bn is spent on health. If the UK Treasury reduces public expenditure (see below) the new Scottish parliament may find itself using its “tartan tax” to stave off substantial cuts in public services.

Table 1 Key indicators of poverty and ill health*

Nation	Gross domestic product (£ per head) 1995	Private health insurance 1995-6 (%)†	Unemployment (%)‡	People reporting longstanding illness (%) 1995-6	Death rates per 100 000‡				
					All causes	Lung cancer		Breast cancer	Cervical cancer
					M	F			
England	10 324	10	6.9	19	1041	77	42	61	6.5
Wales	8 440	4	8.4	22	1096	74	39	61	6.8
Scotland	9 873	5	8.5	20	1217	103	64	63	7.3
Northern Ireland	8 410		7.5	19	1147	81	40	59	3.3

*Data from *Regional Trends* 32, 1997.⁴ †For all ages, 1995-6. ‡Definition according to International Labour Organisation. Data from *Regional Trends* 33, 1998.⁵

¶Rates standardised to mid-1991 UK population.

Table 2 Relative spending levels per head in the four nations of the United Kingdom*

Year	England	Scotland	Wales	Northern Ireland
1985-6	96	121	106	148
1995-6	96	119	112	132

*Data relative to UK average of 100.¹⁷

Is the allocation fair?

The system for allocating resources between the different parts of the United Kingdom will come under increasing pressure and scrutiny. Changes in the spending allocations for Scotland, Wales, and Northern Ireland are determined each year by the 20 year old Barnett formula. This was originally introduced as a way of achieving gradual convergence in spending between England, Scotland, and Wales, yielding closer alignment between expenditure and relative needs. However, unlike the resource allocation formula for the NHS, the Barnett formula is a population based formula rather than a needs based formula. It does not reflect rural needs for education, health, and employment, differences in population density, or ill health relative to the UK average. Planned changes in spending for English programmes translate into proportional changes for Scottish and Welsh programmes according to their respective population shares. Scotland will receive 10.39% relative to England for changes in spending for English programmes (other than law and order), Wales 5.94%, and Northern Ireland 2.92%.^{12 15}

The formula is now being adjusted to take more regular account of population changes and is likely to deliver the "Barnett squeeze" (as was originally intended), which means that Scotland will lose under the revised allocations (table 2). A recently published report estimates that the real total managed expenditure (TME) adjusted for comparable programmes will rise by only 1.8% a year for Scotland against a planned rise of 4.4% a year in total UK expenditure.¹⁴ In 1995-6 the Treasury estimated that block per capita spending in Scotland and Wales was 24% and 18% higher than equivalent spending in England. Politicians use comparisons of block expenditures across nations for political mileage, but these are not valid because of the lack of comparability and changing composition of the blocks, financial expenditure transfers from the block, and the lack of tracking of equivalent English expenditure. But there has been an implicit understanding that a needs assessment will have to be undertaken long before per capita expenditure is equalised, especially given the poorer health and socioeconomic statuses of Scotland and Wales.^{15 16}

Devolution and party policies on health services

What seems certain is that fiscal policies imposed by Westminster, including any review of the formula for public expenditure, will run up against considerably more political scepticism in the new parliament because of a more sophisticated scrutiny than was possible before. The Liberal Democrats, the SNP, and Plaid Cymru have already identified four issues they intend to focus on: public expenditure allocations, the market

orthodoxy that governs the provision of public services, the private finance initiative, and resource accounting and capital charging.

The Liberal Democrats and the SNP give manifesto support for a stronger public services culture but seem reluctant to embark on yet another reorganisation of health services. In Wales, however, Plaid Cymru proposes to abolish NHS trusts. It would restore strategic planning through the five health authorities that will administer and provide secondary care and the 22 local health councils that will be responsible for community health services and community care in Wales. Plaid Cymru is also committed to preventing further closures of hospitals and plans to introduce experimental salaried general practitioner services and community hospitals with greater local accountability. It also intends to challenge the rules on the system of capital charges and private finance initiative. These strategies could mark a major departure from the NHS bill in the way in which services are organised and delivered in Wales.

In Scotland both the Liberal Democrats' and the SNP's proposals centre on restoring planning through a commission on health that would plan future strategy for health care in Scotland. The SNP advocates a return to strategic planning through health boards and local cooperatives. It will be interesting to monitor how the parties reconcile the competing tensions of hospital NHS trusts and newly established primary care trusts. Both parties have a strong commitment to public health including a minister for public health, but the Liberal Democrats also wish to see a new ministry for health and social care. The Conservative party has reasserted its commitment to the NHS but through greater privatisation and encouraging the use of private sector insurance with tax breaks.

Conclusion

Local government, trade unions, and local people are already engaging in the debate on the future of public spending decisions in Scotland and Wales, and with them the new Scottish parliament and Welsh assembly will have opportunities to shape a very different vision of public health. Assistance and legislation from the European Union may also prove important: parts of Wales and Scotland currently qualify for Objective 1 European structural funding, which is reserved for regions in the European Union with an average per capita income of less than 75%. UK spending on public services and levels of healthcare provision is nearer that of Greece, Turkey, and Spain rather than France, Germany, and Scandinavia.

The elections on 6 May are the first step in the devolution process. It is impossible to predict whether and how the new Scottish parliament and Welsh assembly will use their new powers to further the health of their nations. Much will depend on the wisdom, imagination, and vision of their leaders and whether there is the will to redress the legacy of policies that have widened the gap between rich and poor and those living in sickness and in health.

I thank Professors David Heald and Robert Hazell, Drs Margaret Whitehead, Azeem Majeed, Mary Shaw, and David Price for their comments on earlier drafts of this document.

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Decentralisation and equity of healthcare provision in Finland

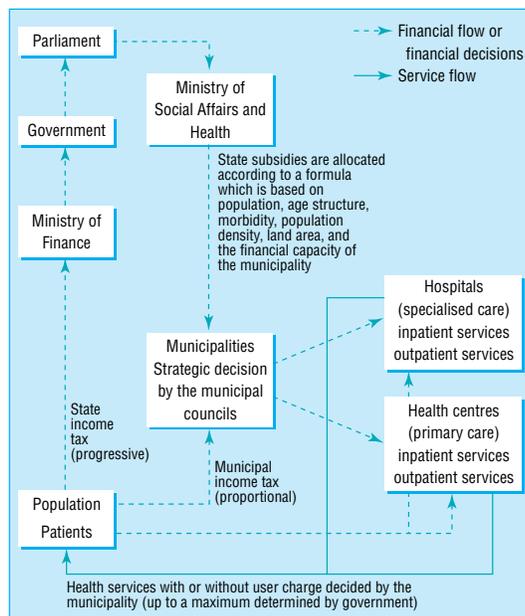
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BMJ 1999;318:1198-200

Finland has a comparatively sparse population of 5.1 million in an area of 338 145 km². Although 66% of the population live in towns, a substantial proportion still lives in rural areas.¹ The nation is divided into 452 municipalities, which have a long tradition of local democracy and local elections. The population and area of the municipalities varies from a few hundred inhabitants to large cities with over 100 000 inhabitants, the median population being 6000. Municipalities have a mandate to raise taxes and responsibilities for providing services, and they can form federations covering larger populations. Central government has traditionally guided this process through legislation and state subsidies earmarked for specific services (figure). These subsidies were particularly important



Finance and provision of public health services in Finland excluding care provided by national health insurance and employers. Adapted from Martikainen and Uusikylä²

Summary points

In Finland the provision of health services is decentralised and the responsibility of municipalities

In practice, central government has traditionally supported these responsibilities through specially allocated funding

In the 1990s central government changed to block grants and municipalities have become more independent in providing services

Municipalities have tax powers, but in the 1990s they have been increasingly collecting funds through user fees

In practice local governance as such may not guarantee equitable access to services or the rights of the most vulnerable groups without legal provision, supervision, and subsidies for poorer areas

when basic services were being provided in remoter and poorer areas, where the maintenance of services is expensive and resources are scarce. In 1993 an act of parliament changed the basis of state subsidies from earmarked to block grants, giving municipalities more independence in using resources.

The Finnish healthcare system has always been comparatively decentralised. Municipalities not only deliver health care but are also major funders of health services with the power to allocate healthcare resources. As well as giving block grants to municipalities, central government also allocates funds from the national health insurance system to cover the costs of drugs and earmarks funds for provincial large and medium sized projects. The five university hospitals