

# Is Devolution Creating Diversity in Education and Health?

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**A report on Health and Education Policy and Performance in Wales and  
Scotland.**

**Prof Colin Talbot, Dr Carole Johnson and Mark Freestone**

**Commissioned by the BBC  
(World This Weekend, Radio 4)**

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# 1 Summary

This research was carried out in August 2004 for the BBC. We have simply collated and analysed existing information about the new devolved governments of Wales and Scotland in the fields of health and education.

We have focussed on inputs (what is being spent), policies and results. This is not meant to be a comprehensive analysis but has focussed on noteworthy issues of difference and divergence. A surprising amount of change is taking place (especially in health), given initial scepticism about just how ‘devolved’ the new institutions would be. But also a great deal remains the same – the underlying educational and especially health problems in Wales and Scotland have not (yet) dramatically improved and in some areas have gotten markedly worse (e.g. waiting list problems in Wales).

Here we provide a simple summary of what we have found so far in gathering and analysing what evidence is available on the policies and performance of the new devolved administrations in the field of health and education. There is often insufficient or not comparable data easily available, and even some that is accessible is subject to suspicions about its reliability (e.g. see Audit Scotland 2004).

## 1.1 Health

	<b>Wales</b>	<b>Scotland</b>
<b>Inputs</b>	<p>Continues to spend considerably more per head of population than England (although less than Scotland)</p> <p>Has tried to revise how this is distributed both geographically and by spending area.</p> <p>However some medical specialities seem to be continuing to increase their share of resources, as against areas like geriatrics.</p> <p>Has continuing financial problems in a number of NHS Trusts (deficits)</p>	<p>Spends more per head of population than any other part of the UK and at European levels of spending</p> <p>Is increasing still further and especially expanding health staffing.</p> <p>Has more beds (6 per 1000) than any other part of the UK (Wales 5, England 3)</p> <p>Has made some redirection of resources into public health.</p> <p>Used a budget under-spend in 2001 to clear historic NHS deficits and provide a “fresh start”</p>
<b>Policies</b>	<p>Has opted for a ‘localist’ model of organising services, with Local Health Boards (equivalent to PCTs in England) co-terminus with Trust boundaries</p>	<p>Has recentralised health through 15 Regional Health Boards and abolished NHS Trusts</p> <p>Has not created equivalent of PCTs</p>

	<p>Strong attempt at local authority involvement and integration with social services</p> <p>Community Health Councils</p> <p>Children's Commissioner</p> <p>Free prescriptions and eye tests</p>	<p>Has created 'Managed Clinical Networks' and aims to give more power to professionals</p>
<b>Results</b>	<p>Health outcomes are poor compared to England but not as poor as Scotland</p> <p>There have been major problems with waiting times (doubling) and seem to be major inefficiencies and capacity misallocation problems</p> <p>Attempts at integration with social services have proved difficult, not least because Welsh local authority social services seem themselves to be performing very badly</p>	<p>Health outcomes seem particularly poor given the level of resources being consumed</p> <p>There seems to be a problem of 'producer capture' with extra resources going into staffing costs</p> <p>There have been some minor improvements in outcomes, but it may be too early to tell</p> <p>There have not been the waiting list problems which Wales has experienced, but there are still problems</p> <p>Public perceptions are poor, with most people thinking the Scottish NHS has not changed or even gotten worse since devolution</p>

## 1.2 Education

	<b>Wales</b>	<b>Scotland</b>
<b>Inputs</b>	<p>Spends slightly more on education but increases in English spending has nearly closed the gap. On average spending for 2003/04 is exactly matched on the per pupil measure with England when London is included.</p> <p>Spending has in fact fluctuated in relation to the differences with England.</p>	<p>Overall, spending has increased since devolution but 2003/04 plans show a 5.92% reduction on the previous year.</p> <p>Spending has been across all sectors including the special needs sector reflecting policy aims for equality.</p> <p>Despite reductions in the overall school spending, spending per pupil is still increasing and is higher at</p>

		<p>£3,770 per pupil than England and Wales.</p> <p>This outcome may reflect efficiency drives to remove spare capacity from the system which from 2002 has been successful.</p>
<b>Policies</b>	<p>The broad drift of policy is remarkably similar to England and Scotland, differences occur in style of management in areas such as testing and league table which have been abandoned for 7 year olds and between school comparisons have also been abandoned.</p> <p>There are new policies for secondary qualifications in the Welsh Baccalaureate.</p> <p>Policies in general match those of England and aim to improve attainment for all in order to reduce disadvantage and lay the foundations for a successful knowledge economy.</p> <p>Policies for nursery education, for smaller class sizes and improved quality and outcomes are similar to English policy.</p> <p>Has set targets, including long-term targets.</p>	<p>Policies very similar to English and Welsh policies.</p> <p>Whilst the Scottish Educational system has been renowned for its quality it has not been renowned for its inclusiveness and equality.</p> <p>The Education debate has highlighted concerns with choice for youngsters particularly those who are not academic and would benefit from more vocational studies.</p> <p>Has similar policies to provide additional nursery places and smaller class sizes.</p> <p>Not surprisingly, given the qualifications scandal of 2000, there is much emphasis placed on rebuilding confidence with the electorate over the quality of exams.</p> <p>Has set targets.</p>
<b>Results</b>	<p>Wales enjoys better educational achievement than England.</p> <p>Spare capacity in the system suggest that greater efficiency could be sought.</p> <p>There are fewer school exclusions than in England but the Welsh are struggling to provide a high quantity of educational provision for those excluded from ordinary classes.</p> <p>Primary level results based on teacher assessments are high and</p>	<p>Scotland has achieved many of its objectives.</p> <p>The extension of nursery places for 3 and 4 year olds is moving slowly, especially it appears where provision has been poor previously.</p> <p>Key results in educational achievement show steady year on year improvements in all categories but the degree of improvement declines as children get older.</p> <p>Standard and higher level qualifications are good. But the data</p>

	<p>reliability tends to be good so these can be taken as equivalents to tests.</p> <p>Like Scotland and England results at key stages fall behind as children get older.</p> <p>Approximately 5% more children achieve 5 or more grade A to C at GCSE than their equivalents in England.</p> <p>Improvements are also being seen in the A/S and vocational equivalents.</p>	<p>is incomparable with England and Wales.</p>
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### 1.3 Overall

- Scotland and Wales continue to spend more on both education and especially health than England does.
- Scotland and Wales probably perform as well or better than England in (compulsory school age) education – comparisons with Scotland are especially difficult however because of the different examinations.
- Scotland and Wales perform worse than England on health:
  - Wales performs especially badly in waiting lists and appears to have on-going financial problems and poor distribution
  - Scotland still has very poor health outcomes despite relatively very high levels of spending, staffing and provision of beds
- Scotland and Wales have developed radically different policies towards health organisation than England:
  - Wales has opted for a localist solution, with some similarities to England (local purchasing) but stronger community and local authority involvement
  - Scotland has gone for reinstating a centralised hierarchy but is experimenting with a more professionally driven system

The big structural and systemic changes in health will take time to work through and as yet unproven. There is some evidence that the disruption of yet more change – especially in Wales – may have caused some short-term problems. Both Scotland’s ‘Managed Clinical Networks’ and Wales’ new localism are different from England’s new quasi-market – whether they will be better or not remains to be seen.

## 2 Is Devolution Creating Diversity in Education and Health?

The creation of Assemblies in Wales and Northern Ireland and a Parliament in Scotland creates a very British solution to central-regional tensions. Not a fully-fledged federal state, but no longer a totally unified one either. A typical piece of ‘muddling through’.

It should also be remembered that ‘devolution’ did not start in 1997. The Secretary of State for Scotland was created in 1926 and the history of the Scottish Office goes back well into the 19<sup>th</sup> century and even beyond. The Welsh Office is a relative newcomer - only being set up in 1964 - but in both Wales and even more so in Scotland a great deal of ‘administrative’ devolution long predated the democratic devolution introduced by New Labour.

One crucial question for citizens will be: does it matter? Will there be, for example, any real diversity and local sensitivity in crucial public services such as education and health? These are not the only tests of the success of devolution, obviously, but they are the sort of issues which most concern the voters.

This brief survey of the evidence so far has been prepared for the BBC and is based solely of collating and analysing existing evidence. We have looked at the two public service areas of health and education in England, Wales and Scotland – where evidence is available.

We have looked at three main areas: has devolution changed patterns of spending on education and health and within each area? Has it led to markedly different policies developing in the three nations? And finally, is it making any difference in the levels and quality of public services?

A caveat needs to be immediately entered – these are very early days in the life of the devolved administrations. If we use a typical model of the process involved in producing public services then it is easy to see that making real changes takes considerable time:

**Figure 1 Changing Public Services**

Phases	What is it?	Timescales
Changing Inputs	Resources devoted to a public service or bits within it	Usually 1-2 years to shift budget allocations in a marked way.
Changing Processes	How public services are ‘produced’	Roughly 2-4 years to make organisational, process, staffing and other changes – maybe longer if large capital investment is needed.
Changing Outputs	What public services actually produce – e.g.	Roughly 3-5 as input and process changes work their way through

	hip operations; pupils being educated; etc	
Changing Outcomes	The ultimate effects of public services in better health and education	Roughly 5-10 years, but in some areas even longer – e.g. changes in children’s services might take decades to work their way through into patterns of adult health, education, criminality, etc.

As the devolved administrations only took up their roles in late 1999 and it obviously takes time for new institutions themselves to settle in and shape their policy agenda’s, it is extremely unlikely we would be seeing a large-scale change in outcomes performance already. At best we could expect to see some substantial changes in outputs – what services are actually being delivered and their quality – by now (assuming of course the devolved bodies decided to do anything distinctly different from the previous patterns or from new developments in England).

## **2.1 A note about comparing spending**

The best way normally of estimating how much of the ‘national wealth’ is being consumed by any particular bit of public spending is to calculate it as a proportion of GDP (gross domestic product).

Just looking at actual spending amounts in countries of different sizes (and wealth) tells you very little which is of any use in comparing public spending. Latvia is obviously going to spend less than America on education. Even within a single country absolute amounts aren’t much use, as the effects of inflation (or more rarely deflation) mean that actual money spent does not necessarily reflect ‘spending power’. Finally, if you correct for inflation (so-called ‘spending in real terms’) this tells you quite a bit more – but it does not reflect underlying changes in national wealth. You can easily be spending more on something – say health – in real terms but less as a share of overall national wealth, if one is growing less fast than the other. Spending as proportion of GDP gives a pretty good idea of how much is being spent and makes it easier to compare across countries.

But there are no separate GDP figures for England, Scotland and Wales<sup>1</sup> so this is not possible. A rather crude comparator which at least accounts for the different sizes of the three countries is to look at spending per head of population. This is crude because it assumes demand (e.g. proportions of school age kids) is the same in all three countries, but it helps get a broad fix on the issues.

## **2.2 The Barnett Formula**

The so-called ‘Barnett Formula’ for spending in England, Scotland and Wales was introduced by the then Chief Secretary to the Treasury, Joel Barnett, in 1978. A

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<sup>1</sup> Attempts have been made to calculate separate GDP’s for the home nations, mostly by those sympathetic to the nationalist causes, but these figures are highly contested and unreliable.

notional population ratio was set (England 85, Scotland 10, Wales 5) which determined how any share of the *increases* or *decreases* (not the total amounts) in a Whitehall spending programme would be translated into budgets for the Scottish and Welsh Office's. This effectively cemented in place spending patterns which favoured Scotland and Wales as against England, a source of continued friction ever since. Nevertheless, no Government – even Mrs Thatcher's – has substantially tampered with the formula. Whilst New Labour has toyed with the idea of changing the formula it has proved politically too difficult, so far, to make substantial changes – despite consistent complaints from English regions.

## **2.3 Devolution - the Background**

New Labour came to power in 1997 committed to devolution. There has been a great deal of speculation about how far the Prime Minister and some of his colleagues were to this agenda and how much it was an 'untouchable' legacy of the late John Smith but whatever the truth the new Government wasted little time in pushing through devolution using its overwhelming Parliamentary majority to overcome some reservations from its own backbenches and the Opposition.

### **2.3.1 Scotland**

Scotland (along with Wales) already had substantial devolved powers but these were controlled through the Scottish Office rather than an elected body. Scotland also had – since the 18<sup>th</sup> century Act of Union – distinctive legal, educational and many other public institutional arrangements.

On September 11, 1997, a referendum was held in Scotland in which voters were asked two questions: whether they were in favour of a Scottish Parliament and whether such a Parliament should have tax-varying powers.

The outcome of the referendum was a majority in favour of the creation of a Scottish Parliament with tax-varying powers. In 1998 the Scotland Act was passed at Westminster, devolving a range of powers to the new Scottish Parliament. On May 6, 1999, the first Scottish general election was held and the first 129 Members of the Scottish Parliament (MSPs) were elected. The Scottish Parliament was formally opened in Edinburgh by Her Majesty the Queen on July 1, 1999.

The key difference between Scottish and Welsh devolution are the status of the devolved bodies ('national' Parliament versus 'provincial' Assembly); powers to legislate directly and power to vary income tax (by 1p up or down on the UK rate) – both in Scotland but neither in Wales. But these differences compound pre-existing institutional differences.

### **2.3.2 Wales**

The situation in Wales differs markedly from that in Scotland both in the degree of integration with English institutions and in the degree of devolved powers. The legal and criminal justice systems in England and Wales, for example, have historically

been the same and remain under the control of the Home Office post devolution. Wales does not have a separate Prison Service, for example, whereas Scotland does.

In July 1997, the Government published a White Paper, *A Voice for Wales*, which outlined proposals for devolution in Wales. These proposals were endorsed in the referendum of 18 September 1997.

Parliament passed the Government of Wales Act 1998, which established the National Assembly for Wales, and the National Assembly for Wales (Transfer of Functions) Order 1999, which enabled the transfer of the devolved powers and responsibilities from the Secretary of State for Wales to the Assembly to take place on July 1st 1999.

The first elections for the new National Assembly were held in May 1999 and produced no overall majority – instead the Assembly is ruled by a Lib Dem-Labour coalition which has somewhat impeded policy formation and “reinforced the essentially conservative value base” (McClelland 2002 p330) present in Wales. However, Greer observes that this does mean that “there are two governments formally in power, and, mathematically, if not always practically, twice as many chances for policy advocates to make their case.” (Greer 2004).

## 3 Health

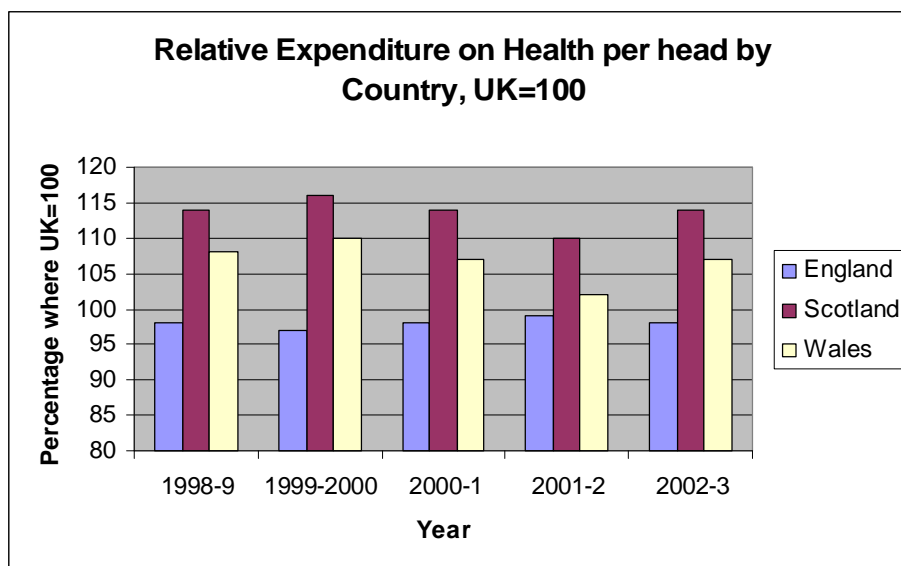
### 3.1 Health Spending in England, Scotland and Wales

Contrary to what might have been expected, health expenditure per head of population shows a slight tendency to converge between 1998-9 and 2001-2, but there is pronounced 'bounce' in 2002-3 back to almost the same levels of divergence as in 1998-9. (In education spending the convergence is even more marked – see below).

One explanation for this might be that as the extra spending on health coming from Whitehall for England kicked in after the 1998 Spending Review (starting in the fiscal year 1999-2000) Scotland and Wales simply did not feed all the increases (derived via Barnett formula operation) through to health budgets but initially used at least some of the extra cash elsewhere in their budgets (which they are perfectly entitled to do). The 2002-3 'bounce' may simply be a case of the new money now being fed through to health?

However the explanation may not be quite so simple, as in Wales for example health spending is claimed to have increased as proportion of the overall Assembly Budget (Wanless and Review Team 2003 p19).

Figure 2



Derived from (HM Treasury 2004)

A common suggestion is that health problems in Wales and Scotland are worse than in England which justifies higher spending levels. Whilst this is true for *average* health statistics it is also the case that some areas of England have worse health problems than the worst areas in Wales, for example (Audit Commission in Wales 2002 p15). And within both Wales and Scotland there are big differences – for

example the former coal-mining areas of the south Wales valleys have markedly bigger health problems – although overall Welsh health needs are less divergent than Scotland or England (ibid, p15).

### **3.2 Divergent Health Delivery Models?**

A recent article published by the UCL Constitution Unit (Greer 2004) suggests that devolution has profoundly affected the localised operation of the NHS in all four of the ‘home nations’, leading to, effectively, four different models of ‘the NHS’, each with distinctive characteristics. Leaving aside Northern Ireland for the purposes of this report:

- Scotland has tended towards a system based on *professionalism* in which it tries to align organisation with the existing structure of medicine. This means reducing layers of management and replacing them with clinical networks, increasing the role of professionals in rationing and resource allocation.
- England’s model is more centred on *markets* in which independent trusts, similar to private firms, will contract with each other for care while approximately thirty regulatory organisations will ensure quality.
- Wales’ NHS system operates an ethos of *localism*. This means integrating health and local government in order to coordinate care and focus on determinants of health rather than treating the sick. It tries to use localism as the lever to make the NHS into a national Health service rather than a national Sickness service.(Greer 2004)

### **3.3 Health in Wales**

In June 2003 a Review Team advised by Derek Wanless (who had carried out the review of the UK Health Service) reported on a specific review of health services. It concluded that the health of the people of Wales remained relatively poor. The main reasons for this were a combination of poor life styles but also large failings in the Welsh health and social care systems.

Prior to devolution there were differences between the English and Welsh health systems – but these were mainly to do with the distribution of resources and performance rather than policy differences. Wales was already performing badly and resources appeared to be badly allocated. **In some respects these problems have become much worse since devolution. The acute sector especially is failing to meet demand and waiting lists have risen exponentially.**

- The total number of patients waiting for an outpatient appointment more than doubled, from 101,308 to 212,352, between March 1997 and March 2002.
- Patients waiting more than six months went from 5,956 to a staggering 68,560.

- Those waiting for inpatient treatment fared better – rising from 37,095 to only 38,717.

Whilst some improvements have been made since this Report, this is not a good advert for the devolution of powers.

### 3.3.1 Spending

Health funding in Wales comprises the largest area of budget spending – amounting to 34% or £2.7bn in 2000 (Jervis and Plowden cited in McClelland 2002) and according to the Wanless report now consumes a larger share of Assembly spending than in 1998-99 (Wanless and Review Team 2003 p19).

Within the overall health budget there appear to be some big issues about where the money is targeted.

The problems in acute services – leading to the big growth in waiting lists – takes place despite the fact that the total number of hospital beds (including acute, community and others) is at 11,000 **37% more per head of population than in England** (Wanless and Review Team 2003 p22). Part of the problem is misallocation: 3,000 of these beds in the community sector are badly used whilst the acute sector is short of bed space (ibid, p22).

A major study conducted in 2001 of health spending in Wales revealed major anomalies in how spending got to front-line services through a very defective formula (Townsend and National Steering Group 2001 - see Chapter 3).

This review also established some general trends which appeared worrying – Welsh NHS Trusts reports<sup>2</sup> showed that whilst medical specialities (28.4% of their budgets) grew by an average of 7.3% per year in real terms between 1996-7 and 1999-2000 and surgical specialities (27.3%) by 5.3% a year, geriatric services (4.4%) fell by an average 10.1% per year (ibid, pp44-45).

There are, despite the generally higher levels of spending in Wales on health services, problems in NHS Trusts:

**“In 2000/01, seven of the 15 [Welsh] NHS Trusts were in financial recovery because of serious underlying financial problems,** and auditors have expressed doubts about the achievement of recovery plans in 4 of these trusts.” (Audit Commission in Wales 2002 p44).

However this is long term problem – in every year but one from 1994-5 to 2003 NHS organisations in Wales reported deficits of over £10m (Wanless and Review Team 2003 p19). Those in the know suggest that Westminster/Whitehall allowed this problem to develop out of political expediency and it has become ingrained as a result.

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<sup>2</sup> The report does point out these figures from Trusts are un-audited and somewhat suspect.

### 3.3.2 Policy

Greer's analysis (cited above) that Welsh health policy since devolution is characterised by an approach focussed on localism may well be correct, at least at the level of policy rhetoric (Greer 2004). However, it has to be remembered how closely knit the Welsh health policy community has become since the administrative devolution of the 1960s. The health policy community in Wales has been described as:

“closely integrated... a clear set of vested interests were institutionalised within the Welsh Office...” and further that there has emerged “a high level of convergence amongst members of the policy community regarding the nature of the NHS itself. (McClelland 2002 pp328-329)

Greer also observes: “The Welsh public health strategy is in theory quite different from that pursued in other UK systems. Rather than seeking to use a health service to promote health, it sets health outcomes and views the health services as a tool that will help achieve them...” (Greer 2002). Again, this may be true in terms of policy but the actuality on the ground appears to rather different.

The biggest innovation in Wales is to create Local Health Boards (LHBs) as the main health ‘commissioning’ bodies – equivalent to Primary Care Trusts (PCTs) in England. But with big differences – LHBs are co-terminus with the 22 unitary Local Authorities in Wales; they are mandated to be more closely tied into the Local Authorities and Community Health Councils; they are required to adopt a more preventative strategy; etc. This does not entirely remove the ‘market’ element introduced by the supposed LHB/PCT ‘commissioning’ role but it places much more emphasis on ‘localism’.

A key part of this strategy is better integration between Health and Social Services (to deal with issues like after-care, bed-blocking, etc).

Greer identifies the problems of ‘capacity’ (within health management and systems) and reluctance of central politicians and officials to ‘disengage’ as crucial problems inhibiting the success of this model (Greer 2004 p17-18). The performance problems detailed below suggest even bigger problems.

There have been some other specific policy initiatives which clearly stand out as different from England and ‘New Labour’, for example:

- One of the first policy acts of the Welsh Assembly was to appoint a ‘**children’s commissioner**’ - a lead England has still not followed.(Eaton 2001)
- Further, the National Assembly – despite advice from the Chief Medical Officer – has extended **free prescriptions and free eye tests** to the Welsh population (McClelland 2002 p330)
- **Community Health Councils** are still a central part of health policy in both Wales and Scotland, despite their abolition in England in 2002

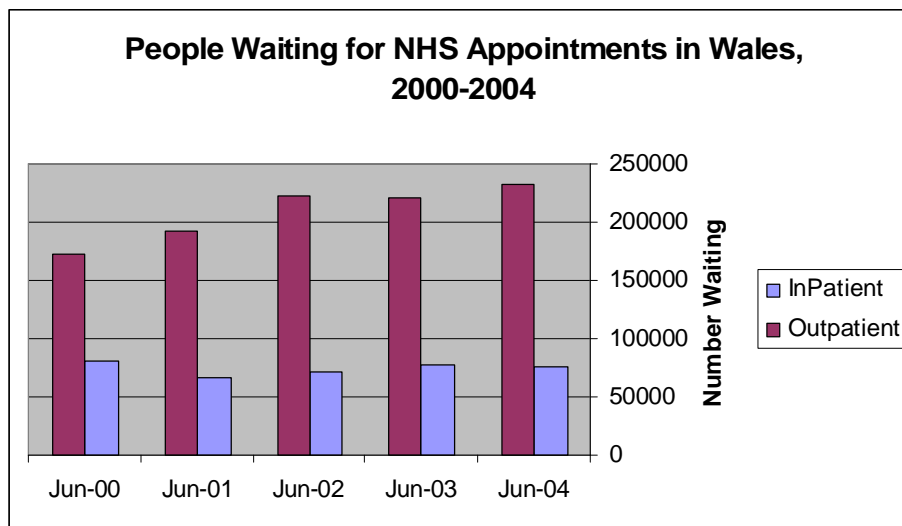
### 3.3.3 Results

We have already mentioned the massive growth in waiting lists.

“At the end of March 1997, there were about 100,000 people waiting for outpatients appointments in Wales and under a thousand of whom had been waiting for over a year. By the end of December 2001, the total number waiting had more than doubled, to 211,000. About 68,000, or a third, of those people had been waiting more than 6 months; nearly 26,000 (12%) over a year...” (Audit Commission in Wales 2002).

“... [W]aiting times for inpatient admission are also typically longer in Wales than in England. At the end of December 2001, some 5% of people waiting for ordinary inpatient admissions in England had waited for over a year, only a handful of the waiting for over 18months. And the number of those waiting for a year or more had fallen by 29% on the previous quarter. **In Wales, by contrast, 21% of people had been waiting over a year for inpatient admission, with several thousand waiting as long as 18 months...**”(Audit Commission in Wales 2002)

Figure 3 Waiting Lists



(National Assembly for Wales 2003)

Some of these problems were strongly localised. Just 3 NHS Trusts – Gwent, Cardiff & Vale and Swansea – had between them around 22,000 people awaiting inpatient care (Audit Commission in Wales 2002 p21). This presumably not was intended by the more ‘localist’ agenda.

On the more positive side complaints are down - there were 5,475 complaints about the NHS - down 6 per cent on the previous year.

- Between 2000-01 and 2001-02, the total number of NHS beds, including mental health, learning disability maternity and geriatric medicine beds, fell by 129 (1 per cent) to 14,435.
- The number of beds in acute and geriatric specialties fell by 40 (0.4 per cent) to 11,080 but the number of beds in medical acute specialties rose by 173 (3.7 per cent).

Overall levels of funding for both local government and health services in Wales are higher than in England, but performance is mixed. On the health side, some services, such as A&E, outperform those in England. In other areas, Welsh performance is behind. Patients face long waits for certain types of hospital treatment and, in some areas, commissioners and providers need to do more to improve the efficiency of day surgery and immediate care, both of which could contribute to effective bed management in hospitals.

“Organisational changes whether within a UK or a devolved NHS seem to date insufficient to alter a value base entrenched and reinforced by health policy communities... it seems debateable whether devolution will significantly shift the Welsh health policy process to allow for inequalities in health to truly permeate the future policy agenda.” (McClelland 2002).

Despite a pledge from the incoming coalition administration in Cardiff to provide a period of respite from changes in the Welsh NHS, the actual agenda became one of fairly radical structural and systemic change. Given the historic weakness of systems inherited from the Welsh Office and problems in specific areas of local government (which had also only recently been through the massive reorganisation into unitary authorities) the new localist agenda may be seen to have been a “brave decision, Minister”, as Sir Humphrey would say. Attempting to placing power in the hands of a fairly disparate group of stakeholders (LHB’s, local authorities, as well as the traditional power groupings within the health system) may have been over ambitious. The more traditional power centres favoured by other reforms (managers or professionals) also have their problems, but at least are relatively tried and reasonably well understood.

Finally, the part of the strategy which relied on better integration between Health and Social Services may also have been somewhat over optimistic in the situation where Welsh Social Services were performing very poorly. Every one of 12 Welsh Social Services departments inspected between 2000 and 2002 were judged to fail to meet the standard of “serving most people well” or better (compared to 30% who met the standard in England) (Audit Commission in Wales 2002 pp28-29).

### **3.4 Health in Scotland**

#### **3.4.1 Spending**

The NHS in Scotland spends currently about £7 billion – around one third of the entire Scottish Executive budget – and is set to increase to around £8 bn by 2005-6 (in constant prices), up from around £5 bn in 1997-8 – an average increase of 6% per

year. Spending per head of population is set to rise from £1,400 in 2002-3 to £1,700 in 2005-6, partly due to rising budgets and partly declining population. This is higher than England and already matches the level of healthcare in other European countries.(Audit Scotland 2004 Part 3).

With 147,000 staff, NHS Scotland also has more hospital doctors, GPs and nurses per head of population than England but the Scottish Executive plans to increase staffing further with 600 more Consultants, 12,000 extra Nurses and 1,500 other health professionals (Audit Scotland 2004 p19).

As a result of these levels of spending, Scotland has 6 hospital beds for every 1,000 people compared to 5 beds in Wales and Northern Ireland and only 3 in England. The picture in acute beds is less stark, only 3.5 beds compared to 2.8 in England, and 4 and 3.8 in Wales and Northern Ireland respectively.

The emphasis in spending has changed slightly, with additional investment in areas such as coronary heart disease, stroke, cancer and mental illness – addressing what are the worst areas of performance in Scottish health outcomes.

In 2001 the Scottish Executive under-spent its overall budget by some £700m and used the opportunity to wipe-out long term financial deficits accumulated in NHS Scotland – similar to those in Wales - and put at around £90m (Parker 2001). This gave NHS Scotland bodies a “fresh start” and even provided a small cushion against future problems.

### **3.4.2 Policy**

Health policy – at least in terms of the structuring of health provision – has struck out in a radically different direction to either England or Wales.

The new Scottish Executive has:

- At first marginalised and then abolished NHS Trusts
- Integrated all management of the NHS Scotland through 15 Regional NHS Boards
- Implemented ‘Managed Clinical Networks’ focussed on a clinical problem (e.g. cancer) that manage resources and service delivery
- Has not created Primary Care Trusts or Local Health Boards, as in England and Wales respectively

(Scottish Executive 2003; Greer 2004)

This approach is a combination of old-fashioned centralisation and command and control style planning with a strong element of what Greer calls ‘professionalisation’ – i.e. potentially handing a considerable amount to power to the medical and other professionals through the ‘Managed Clinical Networks’ (Greer 2004 p10).

Paradoxically, perhaps, Scotland has however embarked on a health policy which places greater emphasis on public (preventative) health. Given the prominence given to the medical elites this would seem strange – their emphasis is usually on acute, high-profile and highly technological solutions. However, a combination of the political prominence of Scotland's clear health deficit's in areas of 'social disease' – such as heart disease, cancer, mental illness and suicide all related to living conditions and life-style – and the fact that in Scotland public health is in fact a prominent and well organised lobby within the medical establishment (Scottish Executive 2003; Audit Scotland 2004; Greer 2004).

The above changes have tended to be over-shadowed by some more headline grabbing measures, such as the decision in 1999 to introducing free care for all elderly people, regardless of means.

### **3.4.3 Results**

The fact that Scotland's health policies have shifted towards 'Managed Clinical Networks' (MCNs) and public (preventative) health means that it likely to be some time before the results can be observed. The reorganisation in the direction of MCNs is taking considerable time and resources presently are still distributed primarily through the (recentralised) hierarchical structure of NHS Scotland. Moreover public health policies focussed on outcomes are bound to take considerable time to implement and see results from.

However there are results worth noting. The recent Audit Scotland assessment is not very positive:

- Information on which to judge results is lacking and somewhat unreliable
- The moves to create ever more medical and nursing posts, when Scotland already has relatively high numbers, are creating built-in long-term cost pressures
- Despite having more beds per head of population than the rest of the UK, Scotland has the lowest bed occupancy rates
- There have been improvements in waiting times (unlike Wales big increase in waiting), but problems remain
- The initial outcomes picture is mixed, with some small improvements in things like smoking levels, deaths from cancer have however remained static – lung cancer deaths for men have reduced but for women have actually increased

A highly critical study from the right-of-centre think tank Civitas recently concluded that higher levels of health spending were subject to 'producer capture' – i.e. the costs of producing health care were absorbing resources and not producing extra health services (Irvine and Ginsberg 2004). The analysis by Audit Scotland certainly shows

that staffing levels and costs have absorbed a large proportion of extra resources (Audit Scotland 2004).

Popular perception of NHS Scotland is also disappointing – most people see no improvement or health services are getting worse. The table below shows the public’s perceptions of the NHS in Scotland over the last few years. “Although half (48%) of the public feel that the NHS has remained unchanged over the past few years, more think it has deteriorated than think it has improved. Around one in seven (14%) say that the NHS has been performing much better (3%) or a bit better (10%). On the other hand, around three in ten (30%) think it has got a bit worse (17%) or much worse (13%). This results in a net performance of –17% as a whole. In other words, 17% more people rate the NHS as having got worse than rate it as having improved” (Central Research Unit - Scottish Executive 2001).

**Figure 4: Ratings of the NHS over the last few years (%)**

	Total	Sex		Age				
		Men	Women	16-24	25-44	45-64	65+	75+
<b>Base (unweighted)</b>	<b>3052</b>	1241	1811	273	1246	1037	496	138
<b>Much/a bit better</b>	<b>14</b>	15	12	17	11	12	19	25
<b>A bit/much worse</b>	<b>30</b>	26	35	15	32	37	27	15
<b>Net score<sup>3</sup></b>	<b>-17</b>	-10	-23	+2	-21	-25	-9	+11

Source - (Central Research Unit - Scottish Executive 2001)

Despite the Scottish Executive’s commitment to long-term free personal health care for the elderly (above), **satisfaction with NHS performance is lowest in the 45-64 age group**, although it is highest in the 75+ age group.

John Garner, chairman of the BMA's Scottish council, expressed cautious optimism about the impact of devolution, and said he had “**noticed a positive change since the Scottish Executive took control of the NHS.**” (BBC News 2004)

<sup>3</sup> The net score represents the proportion of respondents who think that the NHS has got 'much' or 'a bit better' minus those who think it has got 'much or 'a bit worse'.

## 4 Education

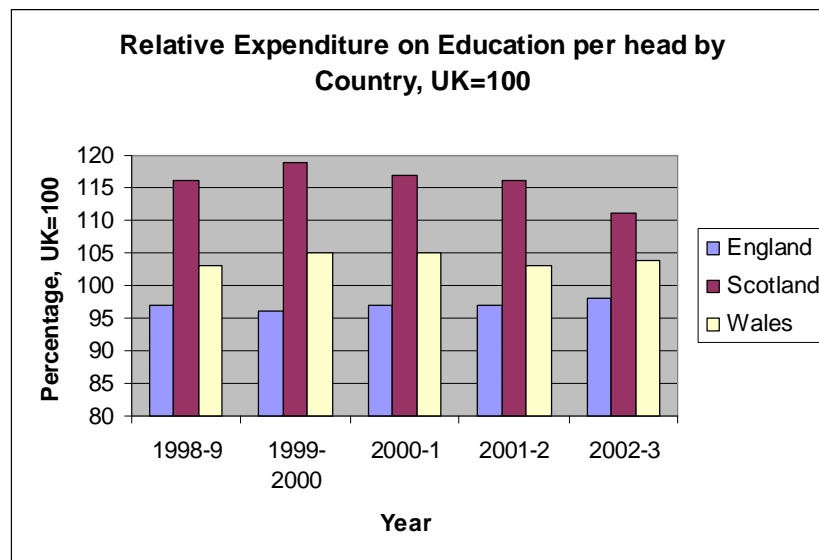
The Educational systems of Scotland and Wales differ in that Scotland always had a separate system from England – especially at secondary schooling level – whereas Wales was identical to England. This makes some of the comparisons between Scotland and Wales somewhat difficult, as Wales clearly had more potential scope for carving out a new system for itself (this is what is called ‘path-dependency’ in academic jargon – even the same reforms can differ depending on where you start from).

### 4.1 Education Spending in England, Scotland and Wales

Scotland and Wales have traditionally spent more on education than England per head of population. There are arguments about whether this relates to different levels of need, but it is clear this is a long term and entrenched pattern.

Contrary to what might have been expected, the global spending per head of population on education in the three countries seems to be converging rather than remaining, or even growing more, diverse.

Figure 5



Derived from (HM Treasury 2002; HM Treasury 2004)

**England's per capita spend has slightly increased towards the UK average, as Wales and especially Scotland's, has come down.**

This levelling out of overall education spending is a big surprise. There has clearly been a big increase in education spending in England, but if the Barnett Formula is

working and Scotland and Wales spent their additional education-related allocations on education then the existing pattern should remain relatively static. Convergence is most unexpected. The most likely explanation is that Wales and especially Scotland have not been spending all their 'education' increases on education this doesn't quite make sense to me - where else might they spend it?. They are perfectly entitled to do this – indeed under the Barnett Formula the Scottish and Welsh Office's could do this before devolution – but it is surprising if they have opted to do so. The popular perception – especially because of things like Scottish policy on University tuition fees – is that the devolved bodies are putting as much or more than Whitehall, not less, into education programmes.

## 4.2 Education in Wales

### 4.2.1 Spending

Whilst convergence in spending may be taking place, investment in education in Wales has been at a healthy level. Jane Davidson, Minister for Education and Lifelong Learning, argues that spending on schools is at an all time high and rumours to the effect that spending in Wales was falling behind their English counterparts was unfounded (press release 02/03). The actual overall comparison between the two regions is now the same. In fact the figure of £3,377 per pupil spent in England is matched exactly in Wales. Average budgets continue to be ahead of England's due to spending in London being higher than other part of England taking into account the demands made by the London weighting.

Figures on comparative spending in the two regions from 1990/91 to 2001/02 show that the education budget for Wales has increased by 27% and England by 24%. This suggests that spending in England has increased considerably more recently.

Total spending on education since 1998/99 is shown in table ? below. This shows a steady increase in spending since the establishment of the Welsh Assembly. Figures for comparative spend show constant fluctuations in the amounts spent by the English and Welsh overtime such that analyses are difficult to make on longer term trends.

Table showing Welsh education expenditure and actual and percentage differences on spending compared to England (Local Government Finance Statistics Unit 2002/03).

	1998/99	1999/00	2000/01	2001/02	2002/03*
Total spend (£M)	1,325.0	1,382.2	1,487.5	1,578.1	1,579
Spend per pupil	2,742	2,853	3,059	3,247	3,239
Spend per pupil difference	40	36	6	24	13
% spend difference	1.5	1.3	0.2	0.7	0.4

\* Budgeted expenditure

The overall average % increase for Local Authorities in the year 2003/04 is 9.3% for unhypothecated revenue budgets or £261 m (National Assembly for Wales March 2003).

In addition to the overall pattern discussed above, the National Assembly for Wales (NAW) has approved a number of specific new spending packages, for example:

- “Early Years” education programme for all 3-year olds whose parents want it
- £100m extra funding per year for 2001-2004 for school buildings to ensure all buildings in good physical condition by target year of 2010.
- Introduction of Learning Maintenance Allowances
- £27m Basic Skills Strategy to improve adult basic skills (National Assembly for Wales 2001).

These additional bits of spending are not markedly different from English patterns and indeed some simply mirror English initiatives.

#### **4.2.2 Policy**

Education policy is not, yet radically diverging from English education except for in a few areas. Wales has its own National Curriculum established by the 1988 Act which allowed for the Welsh Language and culture to be taught as part of that Curriculum. Increasingly, even before the establishment of the Welsh Assembly, education policy was shaped by the Secretary of State for Wales advised by Welsh civil servants (Daugherty and Elfed-Owens 2003). Thus differences in the Welsh system are well established not new; however, the degree to which this affects performance issues, what the outcomes are for the investment made, may not be overly large.

The most newsworthy has been the abandonment of testing for seven year olds and ceasing publication of schools ‘league tables’ (although the data on which league tables – minus 7-year old SATS tests – is still collected and teacher assessments remain).

The Welsh Assembly’s “Plan for Wales 2001” outlined a number of policies for improving education across all age groups. Like the Scottish situation dealt with later there is little difference in the overall thrust of policy between Wales and England. Education is a key factor in economic development and personal well being and is recognised as such in the policy making community. The mantra for Welsh education is ‘Developing the Learning Country’. The introduction to the education section of the Plan states

‘Creating a sustainable, inclusive and equal Wales means giving people the skills they need to prosper in a modern, creative economy, ensuring no-one is barred from employment due to a lack of basic skills’ (National Assembly for Wales 2001 p5).

It could just as easily be something produced by English central government.

Specific commitments are:

- To give every child a flying start through early years education and family educational projects;
- To have excellent schools and the highest possible expectations for all our children;
- To make Wales an outstanding place to teach as well as to learn;
- To remove barriers to learning;
- To strengthen links between learning and business; and to
- To create new opportunities for work based learning

A novel move in policy direction, but again one that is not out of kilter with trends, is the Welsh 'baccalaureate'. This is something which is different from English policy and would have big implications, but it would have no overall impact unless implemented across all Welsh education. Again, this is likely to have greater impact outside of the issues of standards and performance.

Although too early to make judgements regarding their achievement, NAW has set targets in certain areas so that by 2003/4, there will be:

- Free half-time provision for all 3 year olds
- No infant or junior classes over 30 pupils by 2003/4
- Ensure 90% of classes rated as 'satisfactory' and 50% to be 'good' or 'very good'
- Proportion of FE courses being assessed as grades 1 and 2 to reach 80%
- Train 14,000 modern apprentices

It appears that Wales has been rather slower than England on the issue of reducing class sizes which emphasises the fact that diversity is not always in the right direction. Further targets are set for achievement by 2010 which cover a whole range of quality and attainment issues and are in line with English policy.

### **4.2.3 Results**

In general Welsh educational achievement are good compared to England's. However in relation to efficiency of the system, the Audit Commission has found that in some areas there are significant problems with surplus places, resulting in inefficient use of resources. Some 15% of places in primary schools and 11% of secondary schools in Wales were unfilled in 2000/01 (Audit Commission in Wales 2002 p31).

The changes in reporting in Wales means that key stage one results are not published but the teacher's assessment is and furthermore individual schools are not compared at any level although individual authorities are. There are considerable variations between authorities in Wales just as there are in England which may be due to spending levels; socio-economic conditions or quality issues. Rural councils tend to produce better results at GCSE than the average by 7% (ibid).

There are fewer permanent school exclusions in Wales than in England, however, many authorities struggle to provide the 25 hours, for such pupils, that others receive, with some receiving just 10 hours of schooling (ibid).

At the primary level, teacher assessments suggest that between 79 and 81% achieve core subject indicators at key stage one. However, whilst the figures for key stages 2 and 3 are improving on the tests and teacher assessments they fall considerably towards the end of primary school and on into secondary school. These patterns match those of England and Scotland. In the year 1999/00 at key stage 2, 63% of children reached the core subject indicator. By 2002/03 this had improved to 70%. With key stage 3, the figures are 46 and 54% respectively (National Assembly for Wales 2004).

GCSE results are relatively good though with 50% of pupils on average, attending LEA controlled schools, achieving 5 or more GCSEs at Grade A to C (or their equivalent) over the 2000 to 2003 period compared with approximately 45% in councils in England (National Assembly for Wales 2004).

Results show movement upwards in A/S or vocational subjects from 2000/01 to 2002/03 with 62% achieving grades A to C in the earlier year and 68% achieving this level by the later year (ibid).

## **4.3 Education in Scotland**

### **4.3.1 Spending**

There has been increased spending overall in the school system in both revenue and capital expenditure until the year 2002/03. In 2003/04 plans for school spending have been reduced. The figures show a £4.2 million reduction or a 5.92% reduction.

The breakdown of this trend is incomplete. Available figures from the National Statistics publication show a steady increase in spending from 1998/99 to 2001/02. These increases were spread across the primary, secondary and special needs sectors. And whilst there has been a reduction in spending overall, budgeted school running costs per primary pupil have increased gradually from £1,848 in 1998/99 to £2,586 in 2003/04 and for secondary pupils £2,861 in 1998/99 to £3,770 in 2003/04.

### **4.3.2 Policy**

Pre-devolution, Scotland has enjoyed a reputation for originality and excellence in education deriving from an education system dating back to church initiatives in the 16<sup>th</sup> century by the protestant reformer John Knox (British Council Scotland 2004). For the period leading up to devolution, education policy in Scotland was determined by the Scottish Education Department, which suffered some interference in policy processes by UK Government quangos (Allan 2003).

It might be assumed that devolution would create the conditions for a widening of these differences, however, this appears not to be so. In addition, a more rounded take on the Scottish education system has highlighted that it too has had weaknesses and many are unhappy with the approach regardless of the noted higher achievement among the majority. For some, the education system has been failing in terms of providing quality education for all.

This perspective, that in reality all is not well with the Scottish Education system, was not helped by the fact that the devolved parliament, almost immediately, faced a serious crisis in the summer of 2000 when many pupils received their exam results late or were given the wrong grades. The Scottish Qualifications Authority (SQA) was described as ‘riddled with ineptitude’. An interim report into the affair found “little evidence of checks to prevent errors and omissions, with ad hoc solutions being attempted as successive problems appeared, and ... a clear lack of communication within the body.”(Scott 2000).

Current education policy in Scotland is set within a broader ‘cross-cutting’ policy for Young People which sets out broad aims to *enhance quality of life; close the gap in attainment and well being for disadvantaged children* and to *work effectively with and for the people of Scotland* regarding information provision, engagement in decision-making and ensuring and reporting on the quality of public services. Education policy has thus focused on a wide range of initiatives intended to improve quality. This general approach, it has to be said, mirrors much of English policy for education and the improvement of services for the young generally such as providing better services for looked after children. A quick comparison of key policies such as starting and leaving ages, number of days and number of hours spent in school each day match those of England, suggesting that differences within the school system within Scotland can be overemphasised.

Because Scotland has had a higher degree of freedom from Whitehall policy in general, the changes in policy since 1999 are quite difficult to ascertain. Identified changes since 1999 include the establishment of the HMIE (Her Majesty’s Inspectorate of Education) in 2001 which is directly accountable to Scottish Ministers. In 2000, a new act gave every child the right to education for the first time and in 2002, a national debate on education was launched in which wide consultation was conducted. The responses to this consultation was:

- A need for better buildings
- More professionally qualified teaching staff
- Smaller classes and
- More pupil choice in the curriculum

Whilst the Scottish education system has been held up as an exemplar, Allan (2003) has argued that it has been divisive with its emphasis on targets and standards, whilst rejecting, as other policy areas did, intrusions of the New Right thinking. The newly created Scottish parliament was charged with challenging the orthodoxy and radicalising the system in which social justice could be sought. More pupil choice in the curriculum is a reflection of this perspective.

The main objectives of policy (Education and Young People doc) has thus been to:

- Invest in the teaching profession
- PPP building projects
- Improved services for those with special educational needs
- Promote health and welfare
- Promote equality in provision

- Curriculum development
- Improved assessments
- Improving National Qualifications
- Develop a long-term strategy for education
- Invest in ICT and
- Promote standards

In addition, they have employed classroom assistants and have limited class sizes for the early primary years, and increased pre-school provision with the intention of providing each child of three and four with nursery education just as England has done. However this is budgeted for outside the schools budget and is, despite the duty on local authorities to extend this provision, described as voluntary. Government had a target of 60% in the year 2001/02. Unlike England though, they do not have an overly prescriptive national curriculum, it exists together with extensive guidance in relation to how to employ it flexibly in different situations.

The Scottish have also been keen on using targets for policy, for example, they wanted to build or renovate 100 schools by 2003; employ 5,000 classroom assistants by March 2002; and reduce class sizes to 30 by August 2001; and improve pupil to computer ratios to 7.5:1 and 5:1 for primary and secondary pupils respectively.

### 4.3.3 Results

Overall Scotland have done well, employing 4,300 classroom assistants employed by December 2001; achieving a level of 98-99% of primary year 1 to year 3 classes having no more than 30 pupils; improved computer ratios stood at 18:1 and 7:1 by 2001, both showing considerable improvement on previous levels; increases in nursery education have occurred since 1999, by 2002, 37% as opposed to 20% of three year olds were receiving nursery education. There has also been a slight trend towards provision being extended to a larger degree in deprived wards. However, 50% of four year olds had a nursery place in 1999, a figure which the Executive highlight as being 97%, presumably of those children whose parents want nursery education. This figure has increased very slightly for four year olds ?This suggests that nursery education has expanded to include three year olds where it existed for four years olds, most probably in the more deprived districts where nursery education can be seen to be most effective and necessary.

In terms of educational attainment performance has also improved however, how much this is created by devolution and how much by the new drive across the UK to improve school standards and introduce more holistic policies is a moot point.

**Figure 6 key results in year P2 and S2**

	1999	2000	2001	2002
P2				
maths	66.4	69.4	73.5	75.1
reading	36.6	43.5	48.8	50.8
writing	16.9	25.4	33.3	38.5
attaining level A				

S2				
maths	41.6	46.7	51.2	53.6
reading	44.4	53.1	56.4	58.9
writing %	38.1	43.5	45.9	49.8
attaining level E				

P2 – A grade – most pupils should attain this by P3

S2 – E grade – most pupils should attain this by S2

Table shows steady improvements in all categories. However, like the English situation improvements are lower in the secondary age group than in the primary age group. This situation reflects the issues raised by the debate on education that schools need to work harder with those switched off from education as it is currently organised.

In terms of later achievement, the Scottish Parliament report that ninety-one% achieved 5 or more Standard grade qualifications (the GCSE equivalents) although this figure is not disaggregated on higher and lower and grades as it is in England and Wales. In terms of the Scottish Highers (equivalent to our AS Level), 22 % achieved three or more (The Scottish Parliament 2002).

## 5 References

- Allan, J. (2003). Daring to think otherwise? Educational policymaking in the Scottish Parliament. Journal of Educational Policy. 18: 298-301.
- Audit Commission in Wales (2002). Public Services in Wales: Delivering a Better Wales. London, Audit Commission for Local Authorities and the National Health Service in England and Wales.
- Audit Scotland (2004). An Overview of the Performance of the NHS in Scotland. Edinburgh, Audit Scotland.
- BBC News (2004). Devolution is an 'NHS Success', BBC Scotland. 2004.
- British Council Scotland (2004). History of Scotland's Education System.
- Central Research Unit - Scottish Executive (2001). Public Attitudes to the NHS in Scotland. Edinburgh, Scottish Executive.
- Daugherty, R. and P. Elfed-Owens (2003). A National Curriculum for Wales: A case study of education policy-making in the era of administrative devolution. British Journal of Educational Studies. 51: 233-253.
- Eaton, L. (2001). Distinct Cousins. The Guardian. Manchester.
- Greer, S. (2002). "When Does Devolution Cause Divergence? Health agendas and policy debates before and after devolution." PSA Conference.
- Greer, S. (2004). Four Way Bet - How devolution has lead to four different models for the NHS. London, UCL - The Constitution Unit: 24.
- HM Treasury (2002). Public Expenditure Statistical Analyses 2002-03. London, HM Stationery Office.
- HM Treasury (2004). Public Expenditure Statistical Analyses 2004. London, National Stationery Office.
- Irvine, B. and I. Ginsberg (2004). Scotland Versus England - a comparison of health care in England and Scotland. London, Civitas.
- Local Government Finance Statistics Unit (2002/03). Analysis of Local Authority Budgets for School Services, 2002/03,, National Assembly for Wales. 2004.
- McClelland, S. (2002). Health Policy in Wales - Distinctive or Derivative? Social Policy & Society. 1: 325-333.
- National Assembly for Wales (2001). Plan for Wales. Cardiff.
- National Assembly for Wales (2003). Wales in Figures, National Assembly for Wales.
- National Assembly for Wales (2004). Key Education Statistics. Cardiff.

National Assembly for Wales (March 2003). Wales not being left behind - record investment in education. 2004: Press Release by Jane Davidson, Minister for Education and Lifelong Learning.

Parker, S. (2001). Scottish health gains by underspending. The Guardian. London.

Scott, K. (2000). Scottish exam authority 'riddled with ineptitude'. The Guardian. Manchester.

Scottish Executive (2003). Partnership for Care - Scotland's Health White Paper. Edinburgh, Scottish Executive.

The Scottish Parliament (2002). The National Debate on Education. Edinburgh.

Townsend, P. and National Steering Group (2001). NHA Wales Resource Allocation Review (Volume 1). Cardiff, National Assembly for Wales.

Wanless, D. and Review Team (2003). The Review of Health and Social Care in Wales. Cardiff, Welsh Assembly Government.