

Are There Now Four NHS Systems in the United Kingdom? A Comparison of NHS Structural Changes in Northern Ireland with England, Scotland and Wales.

Derek Birrell and Ann Marie Gray
School of Policy Studies, University of Ulster

Introduction

The range, scope and nature of NHS provision in Northern Ireland is the same as elsewhere in the UK and, as shown by public attitudes data, there is a consensus of opinion about fundamental aspects of the NHS such as the universality of the service with surveys consistently showing strong opposition to the idea that the NHS should be restricted to those on low incomes (Gray, 2008). There has also been agreement that the running of the NHS has been the greatest source of dissatisfaction. The most recent data shows however, that while people in Britain are happier with how the NHS is being run, the level of dissatisfaction in Northern Ireland remains high and now sits at 15% above the British level.

Table 1 Dissatisfaction with how the NHS is run in Britain and Northern Ireland

	1996	2007
	GB NI	GB NI
Quite dissatisfied	28 24	20 31
Very Dissatisfied	22 23	10 14
Total quite/very dissatisfied	50 47	30 45

Source: British Social Attitudes Data (1996 and 2007) and Northern Ireland Social Attitudes Date 1996) and Northern Ireland Life and Times Survey (2007).

A number of reasons may account for this difference in views. In England cash spending on the NHS doubled between 2007 and 2007 (Appleby and Phillips, 2009) and there was a significant reduction in waiting times for in-patient and out-patient treatment. However, as we show in this paper, the same period in Northern Ireland was marked by uncertainty and a prolonged period of administrative and structural re-organisation. There have also been marked reductions in waiting times but these improvements have occurred much more recently than in Britain. The response of the devolved government 1999- 2002, the Direct Rule administration 2002-2007 and the restored devolved government to concerns about health provision was to focus on structural reorganisation. Delays in reaching final decisions were such that it became the custom to leave Northern Ireland out of comparative analysis of the NHS between England, Scotland, Wales and Northern Ireland. Woods (2004, p324) excluded Northern Ireland from his analysis because of complexities stemming from political instability and Greer (2005, p511) noted it has not been surprising that there are not many policy outcomes from Northern Ireland since devolution. With the suspension of devolution policy development and organisational reform were limited (Talbot-Smith and Pollock 2006). Smith and Babbington (2006) also stated that Northern Ireland can be characterised as relatively inactive but with a reconfiguration of structures pending. A series of studies of health and devolution by The Nuffield Trust had left Northern Ireland out of an original report (Jervis and Plowden 2003) and the most recent report was published before devolution was restored, meaning the evidence about the effects of devolution on health had to be based on developments in Scotland and Wales only (Jervis 2008). However, with devolution in Northern Ireland restored in 2007 the final decisions have now been made on a major structural reorganisation of Health and Social Services, as part of a wider Review of Public Administration. It is now possible to describe more accurately the main ways in which the NHS structures in Northern Ireland differ, and will differ, from England, Scotland and Wales; to take account of further organisational changes in Britain, particularly those planned in Wales; to discuss the reasons for the differences and to assess the significance of the differences in structures and their contribution to the debate about four NHS systems in the UK.

The process of change in Northern Ireland

The new Northern Ireland Executive reached an agreement in 2000 on a draft Programme for Government, a task which itself was not without difficulty given the involuntary power sharing nature of the Executive. One of the five main elements of the programme was ‘working for a healthier people’ (Northern Ireland Executive 2001), which as well as developing health promotion objectives contained a commitment to modernise and improve hospital and primary care services. Of major importance was to be another commitment in the Programme of Government, the reform the whole devolved system of public administration in Northern Ireland. The final terms of reference for the Review of Public Administration (RPA) were agreed in May 2000, based on a number of characteristics such as democratic accountability, responsiveness, subsidiary coordination of services, efficiency and effectiveness, seen as consistent with the arrangements of the Good Friday Agreement (RPA 2003). Barely had the review commenced its operations when a few months later the devolved Assembly was suspended. The Northern Ireland Office and the Secretary of State decided that the Review of Public Administration would continue with the same terms of reference and broad approach (RPA 2003, p. 5). Initially it seemed possible that the reform of health structures would remain a separate exercise based on a 2002 paper, ‘Developing Better Services’ (DHSSPS 2002). However, the 2003 RPA consultation paper saw health restructuring put on hold until the way forward with the RPA was clearer. From this time on the Review of Public Administration team was to treat the reform of the health structure as an integral but a distinct part of the Review.

The existing structure in Northern Ireland demonstrated two core principles, firstly, a form of purchaser-provider split with a division between four Boards responsible for planning and commissioning services and eighteen Trusts responsible for the delivery of services. The second principle was the existence of a largely integrated structure between health and social services, with eleven Trusts providing primary care, social work and, in some cases, secondary care. There were also, however, seven hospital Trusts plus one ambulance Trust. The four commissioning bodies were also integrated as four Health and

Social Services Boards. Under this system some thirty-seven quangos operated to deliver health and social services. A Further Consultation document of the RPA was published in 2005 (RPA 2005) and contained major proposals for restructuring the health service. This was based on a number of principles, three of which had particular salience. Firstly, that changes in structures should be based on the continuing integration of health and personal social services. Secondly, that the continuance of the Boards / Trusts divide hindered the government's intention to secure partnership working. It was suggested that the commissioning of the delivery of services need not be separated organisationally and the development of structures should be characterised not by the need to generate competition but by the creation of partnerships between commissioning and delivery (RPA 2005, p. 64). Thirdly, that the new structures should accommodate the proposals on the number of new local councils. Recognising the desirability of coterminosity the document proposed that the existing four Boards and nineteen Trusts would be replaced by five or seven new integrated Health and Personal Social Services Agencies. The existing specialist regional quangos would be reduced in number but there would be an advisory forum on regional services. There was no further report published by the RPA and the consultation process resulted in general support for the proposals.

However, when the Secretary of State and the Northern Ireland Office ministers announced the final proposals they differed in significant ways from the Further Consultation paper (Northern Ireland Office 2005). The new proposals were for the creation of one statutory health and social services authority and five health and social service trusts plus the Ambulance Trust. This was based on a separation between commissioning and delivery of services. The one statutory health and social services authority would commission services and be advised by seven local commissioning groups, although these would not be independent statutory bodies. Services would be provided by five health and social services trusts.

The main justification for this change, to a division of commissioning and provision and centralised control by one quango, was the improvement of performance management. This was a response to an independent review of health and social care commissioned by the government (Appleby 2005). The Appleby review's main objective was to examine

the resource requirements of the Health and Social Care sector, effective use of resources and management performance. However, the Appleby Report did turn its attention to the restructuring proposals, arguing that the RPA proposals for a unitary system of Trusts would not achieve performance management objectives and lacked the necessary incentives and sanctions to encourage providers to improve their performance (Appleby 2005, p. 12). Appleby went on to recommend a separation between the providers of services and the funders/commissioners of services in order to sharpen up incentives and improve performance, and suggested a single pan-Northern Ireland commissioning body. Despite the terms of reference of the Appleby review which stated that it would not revisit areas where reviews had already been conducted or a policy decision already made, the final recommendation of the Review of Public Administration, as announced by Direct Rule ministers, clearly adapted the main thrust of the Appleby recommendations for health restructuring with a form of separation between the provider of services and the funders/commissioners of services. Table 2 below summarises the key policy developments up to 2005.

Table 2 Key Policy Developments in Northern Ireland 2002-2009

<p>2002 Developing Better Services Report</p> <p>2003 Review of Public Administration Paper published</p> <p>2005 Appleby Review of resource issues in health and social care</p> <p>2005 Review of Public Administration Consultative document - proposals for restructuring health system</p> <p>2005 Final proposals announced by Direct Rule Ministers departed from review document</p> <p>2007-2009 – Number of changes by devolved administration</p>
--

The 2005 proposals published by the Direct Rule Ministers proposals for restructuring the NHS indicated a further significant change. The five Trusts as service providers would not be independent with greater devolution from the central commissioning authority, as Appleby had suggested, but instead would be responsible to

the new central body. By the time devolution was restored in May 2007 the change to five delivery Trusts was near completion. The new minister, Mr McGimpsey, declared his intention to give more thought to the proposed changes but accepted that the newly established five Trusts and the ambulance Trust would remain as they are. Following consultation on amended proposals for health and social care reform the main decisions related to the creation of three centralised bodies. In addition to the main Regional Health and Social Care Board responsible for commissioning, funding and performance, there would be a Regional Agency for Public Health and Social Well-being and a regional Business Services Organisation. There would also be five local commissioning groups coterminous with the new Trusts but still with no autonomous status as they would only be committees of the Regional Health and Social Care Board. The minister did, however, act to introduce limited local government representation on two central bodies and local commissioning groups but not on the delivery Trusts. Despite an earlier statement by the minister that he remained to be convinced that the work of the existing four community health councils would be improved by establishing one large organisation, the final decision was for a single patient and client council for the whole of Northern Ireland.

The new structures overall have been described the most fundamental change to the health and social services system for decades (RPA 2006a). This raises the question if the implementation of this restructuring, which proceeded over 2008-9, has produced an even more distinctive model of the NHS in Northern Ireland compared to England, Scotland and Wales. A number of key elements of the structures are examined; organisation of primary and secondary care, the relationship between health and social care, centralisation, commissioning, c, public involvement, privatisation, public health structures and regulation and inspection.

Main characteristics of structures in Northern Ireland and comparisons with Great Britain

A fully integrated structure for health services

The existing eighteen Trusts were reconfigured into five large new Trusts. These will deliver the NHS services and are responsible for all areas of health provision, primary care, secondary care, community health care and mental health services. This restructuring brought to an end the seven separate hospital Trusts which previously existed for major acute and teaching hospitals. This contrasts with the structures in Great Britain with Primary Care Trusts, Acute Trusts, Mental Health Trusts in England. It also contrasts with existing local Health Boards and hospital Trusts in Wales, although these are to be radically restructured into 7 'all purpose' public health bodies. In some respects it is more similar to Scotland with its fourteen unified NHS Boards providing all health services. Northern Ireland differs from England, as does Scotland and Wales, in not having foundation trust status for health bodies.

Integration of health and social services

The new structure in Northern Ireland moves further towards the complete structural integration of health and social care. There will no longer be hospital only Trusts and the new Trusts fully integrate all aspects of health and social services. This means that Northern Ireland has made more progress towards formal structural integration than Great Britain, despite the commitment in the NHS Plan (DoH, 2000) to breaking down the barriers between health and social care and permit a new form of integration through Care Trusts. Only ten such Trusts now exist in England and these are mostly focused on mental health services with three formally called mental health and social care trusts. Care trusts are located within the NHS and three have now foundation trust status. In England and Wales partnerships remain the main form of joint working and collaboration between the NHS and local government social care services. Scotland has adopted community health and care partnerships as the main vehicle for collaboration between the NHS and local authorities.

The actual impact and robustness of the integrated structure in Northern Ireland have been questioned. Hudson and Henwood (2002) argue that the integration was more apparent than real and did not result in better services than in Great Britain. Research

(Reilly et al, 2007; Challis et al, 2006) indicates that the integrated structure in Northern Ireland was conducive to more integrated work and practice in mental health and services for older people than in England. Heenan and Birrell (2006) suggest that the full potential of the integrated structure has not been realised but there have been benefits in the form of integrated teams and ease of hospital discharges. The integration of health and social care may now lead to improved joined up services and may facilitate seamless services but there are risks involved, particularly concerning the domination of health provision over social care, and the diversion of resources to the acute sector. Children's services, mental health, learning disability and community care could have less priority than acute care and become even more marginalised. In general this raises the more longstanding danger of the basic values and skills of social work and social care becoming subordinate to medical or nursing models.

The restructuring in Northern Ireland significantly reduces the number of health and social care delivery trusts. The five Trusts are very large organisations in terms of population and several are among the largest health related Trusts in the United Kingdom. The South Eastern Health and Social Care Trust is responsible for a population of 444,000. It can be noted that Wales, with a population of 2.9 million compared to 1.7 million in Northern Ireland, has had 60 bodies to carry out the same functions as seven bodies in Northern Ireland. The question arises whether this is too streamlined or sparse a structure for such a wide and comprehensive range of health and social care services, including child protection. This minimalist Northern Ireland structure may not be compatible with public sector modernisation themes of decentralisation and public engagement.

A highly centralised structure

A centralised Regional Health and Social Care Board has replaced four Area Boards. It is responsible for commissioning services, overall delivery of services, performance management of Trusts and Agencies, ensuring the quality of local services, human resource planning, enforcing clear strategic management and financial control, promoting an incentives framework and holding providers to account. This is a much

more significant role than exercised by strategic health authorities in England which have a role in developing local strategies for capital investment and workforce development, implementing central initiatives and ensuring professional leadership, but are not commissioning bodies (Baggott, 2004). The structure specifies that the delivery Trusts are accountable to the centralised Regional Board and may compromise the independence and authority of Trusts.

The Department also retains responsibility for regional strategic development, policy review, advice and support for ministers, legislation, financial priorities, managing performance, and the prioritisation of resources, setting targets and monitoring. Taken together with the centralised regional board this may amount to a command and control model (Gorsky, 2008). Following the restoration of devolution two other centralised bodies were established, a regional public health and well-being body and a common business services organisation. This structure stands in contrast to the much more localised and locally led structure in Great Britain. Social care remains very much a localised service at local government level in England, Scotland and Wales.

The key to the degree of centralisation is the operation of large quangos at arm's length from government. The appropriateness of such a structure can be questioned, not only on grounds of size but in the context of the existence of devolved government as they reduce direct political accountability for services and reduce the policy capacity at the centre. This structure, based on quangos, is also incongruous with public and media perceptions since devolution which invariably look to the minister and department, followed by the Northern Ireland Executive and Assembly, when health and social care issues and problems arise. There is already evidence of the minister taking final decisions on efficiency changes proposed by Trusts, which may raise questions about the rationale for a complex quango structure and about where responsibility ultimately rests.

Commissioning structures

The new structure sets up a unified commissioning system covering all health and social services. In practice the system for commissioning clearly rejects the position of

the 2003 Review of Public Administration document which called for a collaborative and cooperative approach rather than a commissioning / provider or a competitive split. While this largely reflects the existing system it is different from the more fragmented structure in England and from Wales and Scotland. While the Appleby Review (2005, p12) had proposed a clear separation between commissioning and provider bodies to sharpen incentives and performance, the actual final proposals did not adhere to this recommendation. Instead the five provider Trusts are actually made responsible to the single commissioning body. A key problem of the proposal for five local commissioning bodies is they will lack autonomous status or independence and they will operate as local offices of the central Regional Health and Social Care Board and are likely to be directed and controlled by that body. It appears unlikely that there will be real laissez-faire commissioning in that the commissioning body or local bodies will not be permitted to shop around for the best value from the provider Trusts. In practice the commissioning structure will plan/fund services for the local trust, apart from clinical regional specialist services. In a form of double commissioning, the delivery trusts will be able to commission social care services.

Commissioning has also been an issue in Wales where in 2008 the Welsh Assembly Government decided to end the commissioning / provider structure of boards and trusts for health. One argument for this change in Wales was that in practice boards commission services from the local trust with little involvement of alternative providers and therefore, in reality, no real market choice exists (Welsh Assembly Government, 2008). This is clearly a criticism that could be applied to the Northern Ireland commissioning structure. Scotland abolished commissioning in 2004 thus leaving England currently as the one country with the clearest system of market commissioning.

Public involvement

A major deficiency of the new structures in Northern Ireland compared to Great Britain is the low level of public participation, both by the public and users and by elected representatives. The mechanisms for public participation and public involvement are very limited, with the proposal for only one top down appointed Patient and Client

Council. It is not apparent how one such patient and client council can be responsive to local issues, ensure that services are patient-centred or that decisions reflect public views. Findings from the 2007 Northern Ireland Life and Times survey show that the public in Northern Ireland think that they should have a say about issues such as the reorganisation of hospital services and greater choice over, for example, what hospital they would go to for treatment and about the kinds of treatment they would receive. However, only 54% of those surveyed believe that they would have the opportunity to put forward their views about hospital reorganisation. Interestingly, people in Northern Ireland were more likely to say they wanted a 'great deal of choice' about which hospital they would go to (36%), compared to 26% of people in England – where the greatest ability to choose exists. But only 3% of people in Northern Ireland felt they would have 'a great deal of choice'.

The mechanisms for public/patient involvement in Northern Ireland stand in contrast with existing arrangements in Britain where in 2001 a government paper had advocated a shift from a 'paternalist' model of decision making towards a model where citizens have a say in how services are designed, developed and delivered. This led to the Public and Patient Involvement initiative (PPI) which established PPI forums in each Primary Care and NHS Trust. Also established in each Trust were the patient advice and liaison services to provide feedback plus other patient participation groups.

In Wales participation has been built into the management of services in setting service priorities, shaping improvements to services and considering how services should be delivered (Welsh Assembly Government, 2004) with the Welsh structure of 19 Community Health Councils. In 2009 the Welsh Government issued a consultation paper proposing replacing the 19 Community Health Councils with 7 new Community Health Councils with 23 area associations, one on each local authority area (Welsh Assembly Government 2009). The rationale for these changes is to strengthen the role of the Community Health Councils and ensure they have a key scrutinising role in relation to the planning and delivery of services. In light of this it is proposed that the new councils should have responsibility for systematically gathering the views of local people, the authority to inspect premises where NHS services are delivered, have a scrutinising role

in relation to planned policy and delivery developments and performance and provide a complaints advocacy service. It is also proposed that the Councils should be representative of local communities, including local authority and local voluntary sector membership.

In England there has been significant policy development with a series of initiatives in the area of public and user participation. Proposals for new local involvement networks for health and social care (LINKs), both for commissioning and provision (DOH, 2006a) were endorsed by a July, 2006 white paper 'A Stronger Local Voice' (DOH, 2006b) as part of what has been called 'Empowering the Front Line' (Morris et al, 2006). Local involvement networks will be set up in each local authority area to engage with health and social care organisation. In England there is a further local democratic level of scrutiny through Health Overview and Scrutiny Committees in each local council to review and scrutinise health service matters. Under the Local Authority Regulations 2002 NHS organisations are required to consult the overview and scrutiny committees on proposed developments in health services.

The English developments appear to have had some influence on Northern Ireland and the Health and Personal Social Services Reform Order 2007 requires bodies to develop a plan for engaging service users and the public. However, it is not clear how 'consultation schemes' by the Trusts and Health and Social Care Regional Board can equate with the comprehensive public involvement measures being put into place in Great Britain.

The Northern Ireland Patient and Client Council has markedly more limited functions that now exist in other parts of the UK. As the name suggests the focus is on patient and client 'engagement' rather than broader public involvement which has been at the heart of English developments and more recent developments in Scotland and Wales. There is no separate equivalent of the Patient Advice and Liaison Service or the Independent Complaints Advocacy Service. Also, the Health and Social Services bodies and Trusts have a small membership with few lay members and political representatives. As mentioned above this is in contrast to changes planned by the Welsh government and the decision in Scotland to proceed with the introduction of direct elections to NHS

boards. This raises questions about accountability and transparency in Northern Ireland, particularly pertinent given the longstanding concerns about the overuse of quangos and their remoteness from local communities.

Privatisation

The private health sector in Northern Ireland is small, with only a small number of private hospitals and only 10% of households covered by private insurance. Northern Ireland has also fairly limited use of voluntary and private sectors in providing adult social care services, which means the provider role of Health and Social Care Trusts is still a very important direct function. There is still a mixed economy of residential provision for older people, with a three way split between statutory, private and voluntary providers although the new delivery trusts are being encouraged by government to increase the use of the independent sector in domiciliary care. However, one noteworthy point is that PFI is being used in Northern Ireland, albeit in a limited way.

Public Health Structures

Public health has been a priority with all the devolved administrations. The review of the NHS restructuring after the restoration of devolution in Northern Ireland led to a new decision to set up a Regional Agency for Public Health and Social Well-being. This extended the role of the Health Promotion Agency and covers health protection, health improvements, statutory duties and health inequalities. It will have an advisory role in supporting commissioning but concern has been expressed about whether this could impact on the bottom up approach advocated in recent years, especially in relation to health promotion functions. There is, as yet, little clarity about the relationship between the new Agency and the Trusts with regard to the delivery of public health and health promotion services. Wales has also produced restructuring proposals for the unification of public health through a National Public Health Service for Wales Trust which will work with the seven new health boards' directors of public health and social services. Scotland also has a centralized board, NHS Scotland, to take the lead in improving health with each health board having a department and a director of public health. Both Scotland and Wales have set up separate public health observatories. England has elements of

centralization with the Health Protection Agency but localized provision in other aspects through Trusts, although there are now also regional public health groups. .

Regulation and Inspection

Structures for regulation and inspection and social care have changed frequently and in practice do not differ greatly between the four countries. Northern Ireland has moved to one single body, a Regulation and Improvement Authority, which covers health and social care and also has taken over the functions of the Mental Health Commission. Whilst this may seem similar to England which has moved to an integrated Care Quality Commission to regulate health and social care there are two differences. The Northern Ireland body covers children's social services and there is no separate body equivalent to the National Quality Board to provide oversight and leadership on quality in the NHS. Scotland and Wales have maintained separate bodies for health and social care, the Healthcare Inspectorate Wales and NHS Quality Improvement Scotland, as well as Health Scotland to improve the health of the population. There are separate social care inspectorates in Scotland and Wales. This does raise an issue about the capacity of one public body in Northern Ireland to perform all these tasks. It can be noted that all four countries have their own social care councils / bodies to deal with the registration and training of the social care workforce.

It is possible to conclude that Northern Ireland now diverges in significant ways in its NHS structures from Scotland, Wales and England. These can be summarised as a more centralised structure in Northern Ireland, the fact that it is the only country of the UK to have full structural integration of health and social care and has less provision for public /patient involvement than elsewhere.

Reasons and influences accounting for Northern Ireland differences

A number of reasons can be suggested to explain the differences in the Northern Ireland structures. Firstly, the continuing dominance of what Greer (2007) identifies as managerial elites. His study of the NHS in Northern Ireland over a period of time (Greer, 2004) describes the prevailing ethos as one of administrative conservatism with limited

input from either professional elites, as in Scotland, or local government politicians, as in Wales. The final restructuring of the NHS was not very different from the Department's proposals produced before the Review of Public Administration and, therefore, can be seen as civil service driven. There is no evidence of professional health groups exerting influence and the RPA consultation process had actually shown, "considerable support for the proposal to bring commissioning and delivery together" (RPA,2006b) Secondly was the Appleby Review, which was responsible for the dramatic change from the recommendations of the 2005 RPA proposals. The appropriateness of this analysis can be questioned as it had a focus on hospitals which had limitations given the integrated structure of health and social care in Northern Ireland. It compared Northern Ireland with England as a whole rather than with Scotland or Wales, and promoted a market model. Appleby may have influenced the Direct Rule ministers more than the civil servants as, in the final event, a structure emerged with a high level of centralisation, rather than marketisation. Knox (2007) has argued that the whole RPA decision making process was marked by a tendency to ignore the evidence base. The third factor relates to the continuing commitment to integrated structures for health and social care in Northern Ireland which remain distinctive from England, Scotland and Wales. This feature does mean, however, that social care has little connection with local government structures. This also relates to the fourth factor of the major involvement of quangos in administering health and social care. With restructuring has come centralised quangos and also very large delivery quangos. Issues of local responsiveness, representativeness and accountability have received little attention. Fifthly has been a slow response to the UK modernisation agenda, particularly in relation to personalisation, localism, early years and children's services and in mental health and learning disability. This factor relates closely to the sixth factor of limited commitment to structures for public involvement and user involvement, with few initiatives to match those introduced in England, Scotland and Wales. Developments in Northern Ireland have been marked by the absence of discussion of the rationale or values underpinning public involvement - in contrast to the citizenship agenda in Wales and the ideas of mutualism in Scotland. The minister's assertion that "we must have a patient-led service" (McGimpsey, 2007) is hardly exemplified in the new structures. Action was taken to introduce limited

councillor representation to two central bodies and the advisory local commissioning groups, but not on the delivery trusts.

The final influence that can be evaluated is that of devolution. The review and further consultation on restructuring in 2007/8 by the new minister led only to some further centralisation and ‘quangoisation’ with a somewhat controversial decision to set up a separate public health quango. Devolution does mean that the final decision on planned closure of facilities and major changes in provision rests with the minister. This does raise again the issue of the relationship between the devolved administration and arms-length public bodies and the case for bringing key NHS bodies into devolved governance to clarify direct devolved responsibilities.

Conclusions

NHS structures in Northern Ireland now differ significantly from England, Scotland and Wales. This is not solely due to devolution as a number of structural differences go back to pre-devolution decisions, whether decisions of the Direct Rule administrations or even previous devolved administrations in Northern Ireland. It can also be noted that there has been considerable uncertainty over the final shape of structures. This uncertainty is demonstrated in the changes in the proposals from the Review of Public Administration at various stages, the further consultations and changes introduced by the new devolved health minister after 2007 and the different views expressed on restructuring by the Northern Ireland Assembly Health Committee (Northern Ireland Assembly, 2008). There has been surprisingly little debate in any of these forums on justifying different structures in Northern Ireland from England, Scotland and Wales.

The main divergence in structures which it is possible to identify relates to comprehensive integration, the scope and size of delivery trusts, the degree of centralization, the use of quangos and limited systems of public involvement. The commissioning structure places Northern Ireland closer to England and totally different from Scotland and Wales. The inspection and regulation system is also akin to the system in England rather than Scotland and Wales. Some structures, as for public health, GP services and the regulation of the social care workforce do not vary much. What is also largely unarticulated in Northern Ireland are the values underlying the structures. The integration of health and social care gets a brief mention along with some references to streamlining, world class services, switching resources to frontline services and efficiencies. What has largely been absent has been the setting out of values, as has happened in Scotland and Wales around the themes of mutualism and citizenship. Also unaddressed are questions about what impact organisational differences have on health and social care outcomes, public attitudes about standards of health care delivery and opportunities for public participation.

References

Appleby, S., 2005, *Independent review of health and social care services in Northern Ireland*. Belfast: DHSSPS.

Appleby, J and Phillips, M (2009) 'The NHS: satisfied now'? In A Park., J Curtice., K Thompson., M Phillips., E Clery *25th British Social Attitudes Survey*. London: Sage

Baggott, B., 2004 *Health and health care in Britain*. Basingstoke: Palgrave Macmillan.

Challis, D., Stewart, K., Donnelly, M., Weiner, K., Hughes, J., 2006. Care management for older people: does integration make a difference? *Journal of interprofessional care*, 20, 335-348

Department of Health, Social Service and Public Safety, 2000. *Acute hospitals review*. Belfast: DHSSPS.

Department of Health, Social Service and Public Safety, 2002. *Developing better services, modernising hospitals and reforming structures*. Belfast: DHSSPS.

Department of Health, 2000. *The NHS Plan Cm 4818*. London: the Stationery Office

Department of Health, 2006a. *Our health, our care, our say*. available at <http://www.dh.gov.uk>

Department of Health, 2006b. *A stronger local voice: a framework for creating a stronger local voice* in the development of health and social care services.

Department of Health, 2006c. *Concluding the review of patient and public involvement. Recommendations to ministers from expert panel*.

Drakeford, M., 2006. Health policy in Wales: making a difference in conditions of difficulty. *Social policy*, 26 (3), 543-561.

Gorsky, M., 2008. The british national health service 1948-2008: a review of the historiography. *Social History of Medicine*, 21, (3), 437-460.

Gray, AM., 2008. What difference does a decade make? satisfaction with the NHS in Northern Ireland in 1996 and 2006. *ARK Research Update* , Number, 52 – available at www.ark.ac.uk

Greer, S.L., 2004. *Territorial politics and health policy*. Manchester: Manchester University Press.

Greer, S.L., 2005. The territorial bases of health policy making in the UK after devolution. *Regional and federal studies*. 15(4), 501-518.

Greer, S.L., 2007. The fragile divergence machine? Citizenship, policy divergence and devolution *In: A Trench(ed). Devolution and power.* Manchester. Manchester University Press

Heenan, D. and Birrell ., D., 2006. The integration of health and social care; the lessons from Northern Ireland *Social Policy and Administration,*

Hudson, B. and Henwood, M., 2002. The NHS and social care: the final countdown. *Policy and politics,* 30 (2), 153 -166.

Jervis, P., 2008. *Devolution and health.* London: The Nuffield Trust.

Jervis, P. and Plowden, W., 2003. *The impact of political devolution on the UK's health Services.* London: The Nuffield Trust.

Knox, C., 2007. Policy making in Northern Ireland: ignoring the evidence. *Policy and Politics,* 36, (3) 343-59

McGimpsey, M., 2007. *Review of public administration, getting it right,* statement. Belfast: Department of Health and Social Services and Public Safety.

Mitchell, J., 2003. *Governing Scotland: the invention of administrative devolution.* Houndmills: Macmillan.

Mooney, G. and Poole, L., 2004. A land of milk and honey. social policy in Scotland after devolution. *Critical social policy,* 24 (4), 458-483.

Morris, Z. S., Chang, L. R., Dawson, S. and Garside, P., 2006 . *Policy futures for UK health.* London: Nuffield Trust.

Northern Ireland Executive,., 2001 Programme for Government: making a difference, 2002-2005. Belfast: Office of the First and Deputy First Minister

Northern Ireland Office, 2005. Statement of Minister of Health, Mr Woodward, Health and Social Services Reform, 22 November, 2005, available at <http://www.rpani.gov.uk/account.pdf>.

Northern Ireland Assembly, 2008. Health Committee Report on the Health and Social Care Bill (NIA 21/07) 13/11/08. Report Number 10/08/09R

Reilly, S. Challis, D. Donnelly, M. Hughes, J and Stewart, K., 2007. Care management in mental health services in England and Northern Ireland: do integrated organizations promote integrated practice? *Journal of health services research and policy,* 12 (4) 236-241

Review of Public Administration, 2003. *Review of public administration*. Belfast: RPA

Review of Public Administration, 2005. *Review of public administration further consultation*. Belfast: RPA.

Review of Public Administration, 2006a. *Better government for Northern Ireland*, Belfast: RPA.

Review of Public Administration, 2006b. Review of public administration, analysis of resources to 'Further Consultation'. Available at <http://www.rpani.gov.uk/account>. pdf.

Smith, C., and Babbington, E., 2006. Devolution: A map of divergence in the NHS *Health policy review*, 2, Summer, 1-12.

Stewart, J., 2004. *Taking stock, Scottish social welfare after devolution*. Bristol: Policy Press.

Talbot-Smith, A. and Pollack, A., 2006. *The new NHS, a guide*, London: Routledge.

Tannahill, C., 2005. Health and health policy *In: G. Mooney, and G. Scott, eds. In: Exploring social policy in the 'New' Scotland*. Bristol: Policy Press.

Welsh Assembly Government, 2008. *Proposals to change the structure of the NHS in Wales, proposed new planning system*, [www.new.wales.gov.uk/\(consultations/closedconsultations\)](http://www.new.wales.gov.uk/(consultations/closedconsultations)).

Welsh Assembly Government, 2004. Making the connections: delivering better services for Wales. Cardiff: Welsh Assembly Government

Welsh Assembly Government, 2009. Proposals on the future of community health councils in Wales. Consultation paper. Available at www.wales.co.uk/consultations/health and social care

Woods, K.J., 2002. Health policy and the NHS in the UK 1997-2002. *In: A. Adams and P. Robinson., Devolution in practice*. London: Institute for Public Policy Research.

Woods, K.J., 2004,. Political devolution and the health services in Great Britain. *International journal of health services*, 34 (2) 323-339.

