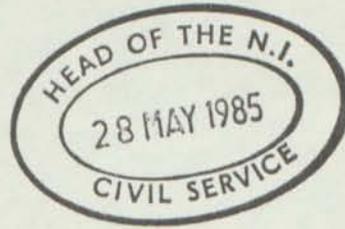


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Mr Bloomfield 2 POL/2



DEVOLUTION PROCESS

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1. Your minute of 17 May seeks comments on a range of options for the government of Northern Ireland. It would give great pleasure to be able to respond positively and optimistically to your invitation, but I am afraid I am almost totally pessimistic about the practicability of any of the options you outline.
2. I am not sure that Government should, in fact, go out of its way to provide a more comfortable strait jacket should the lack of rationality on the part of local politicians result in a failure to achieve devolution on terms acceptable to HMG and to both communities. It should be made clear to the people that there is a price whether in the remoteness of government or the lack of participation in decision making, in failure to reach agreement. I accept that this might suit only too well those elements in SDLP who do not want power and the integrationist wing of the UUP. It will not make any difference to Sinn Fein/IRA, and it may induce some others, after some years of reflection perhaps, to try again on a more realistic basis to secure a devolved administration.
3. If the present initiatives come to nothing, I would argue against the continuation of the Assembly. It is not only District Councils which exhibit insensitivity. Some of the Assembly debates have been extremely partisan, and they serve only to raise the temperature of the community. Without power the Assembly can only become irresponsible. Without responsibility, especially for money, Assembly criticism is even now, all too often an unrealistic catalogue of demands for increased public spending. If a political platform is necessary in which local politicians can blow off steam, that provided by District Councils is surely sufficient.
4. Under the pre 1973 arrangements, hospitals were not (and are not anywhere in the UK) local authority functions. Only community health and social services were transferred from County Councils. Since the major reorganisation in 1973, from which the service is not yet fully recovered, there has been a restructuring following the Royal Commission, and the re-orientation effected by the Griffiths Report on management. We have been pushing initiative after

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initiative at the services, they are now facing a traumatic period of recession and constraint, and I would ask anyone with the interest of the patient and client at heart first to leave the service alone for a period.

5. I now address the specific questions you ask us to consider.

(a) Partial devolution, saving DFP

This is likely to create extreme tension between Departments working to a local political head and DFP working to the Secretary of State. It would be even worse in the absence of any collectivity of interest expressed through either a cabinet or coalition, since the Departmental Heads would not have a common interest, and could also be fundamentally opposed to each other. There would be a tendency to set the Secretary of State up as the financial ogre whose failure to provide funds was stultifying every Departmental effort. There would be no credit for Secretary of State for what was done well, and all blame for failure.

More seriously, the position of officials and accounting officers would be nearly impossible. The exercise of the Treasury function of DFP depends on a degree of trust between Departments and DFP. I could not envisage the present close working relationships continuing under two, perhaps antipathetic, political masters.

(b) Executive devolution

I do not think that the retention of legislative powers makes devolution any easier. As you note, the main grounds for complaint in the past were the exercise of executive functions. Only a very few pieces of legislation were regarded either as oppressive or offensive. In practice, too, it is not always easy to distinguish between policy making and execution. Presumably, however, legislation could be prepared by Departments in the form of draft Orders in Council which would be laid by Secretary of State only if he approved. In these circumstances, the process of prior consultation need not necessarily include a local Assembly.

(c) I will leave comments on the DOE functions to Dan Barry.

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For the first 20 years of the NI Health Service there was a single Hospitals Authority. The tension between the Authority and the then Ministry on a one-to-one basis proved unbearable.

More seriously, the effect of a single Authority was to concentrate development in Belfast and the East. Only since the Area Board structures were set up in 1973 have we begun to correct historic imbalances in the provision of services and in medical manpower.

Apart from that, the thrust of policy, both nationally and regionally has been to reduce the number of tiers, to bring units down to manageable size, and decision making nearer the patient and client. The effect of this was to remove the Area Health Board tier in England, to recommend 150,000/200,000 as the optimum size of District (or Area) and to keep the number of units per District to a manageable span. By these criteria the present Eastern Board is too big, and would be split, if we knew how. A single Board for NI would be regarded as a monster, and would run completely counter to developments.

I can see the possibilities of regionalisation under General Managers in single function authorities like housing or roads. It would be much more difficult in health in providing a chain of accountability on management rather than on professional lines would severely fracture the structures we have been trying to develop.

I might say too, that having worked for years now to integrate community health and social services within the hospital service, thus providing a continuum of care, I would deplore the separation of these services now on the altar of devolution.

(e) Elected majority on Boards

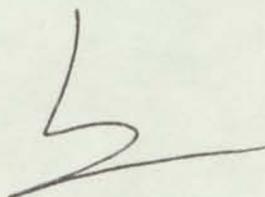
Health Authorities were set up in 1948 as a device to insulate the clinician from the politician and to preserve and protect clinical freedom from political directives. The doctors in 1948 did not wish to be employed by elected bodies and would not have joined the health service on these terms. There would not have been a national service. Nothing in my experience leads me to believe that doctors and their professional and representative bodies have altered this

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stance. The BMA will resist in Northern Ireland; doctors here are very conscious of the maintenance of parity with their GB colleagues and accepted with some reluctance in 1973 the rather higher proportion of district council nominees on Boards here (30%) as against GB (25%). They would not, I think, stand for or co-operate in the politicisation of Area Boards.



M N HAYES
DHSS
24 May 1985

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