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‘The better we are watched the better we behave’. Are devolved parliaments providing a better window for oversight?

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Introduction

The title of this paper indicates that I am concerned with identifying ‘better’ oversight by elected representatives after devolution in the United Kingdom. Better may require more parliamentary ‘watchers’, watchers spending more time on oversight, better informed watchers or watchers whose oversight lens has opened up into either wide angle mode, allowing them to take in dimensions of policy previously missed or close-up mode which allows for detailed scrutiny of local delivery issues. In the United Kingdom the devolution programme launched in 1997 created parliamentary/assembly institutions which promised to realise some or all of these watching potentialities, yet there was also a distinct possibility that the quality of oversight conducted in the devolved parliaments/assemblies would not as high as that pursued in the House of Commons.

The paper examines the health policy oversight systems operating in the United Kingdom, Scottish, Northern Ireland and Welsh parliaments/assemblies with specific comparisons drawn between current rules, practices and behaviours evident in parliamentary committees. Focusing on the 2007-8 parliament/assembly sessions, comparative data is presented relating to the attendance by members on committee, the amount of time devoted to health policy oversight, the percentage of committee places held by non-government party members, cross examination of key witnesses and hours spent examining the budget. Institutional obstacles and incentives relevant to effective oversight are compared.

Method

An initial content analysis of transcripts and associated documents from health committee meetings held in each of the institutions during 2007-8 has provided the quantitative data used for comparative purposes. The paper also draws on interviews with subjects associated with health policy oversight in the four parliaments/assemblies, conducted during
the course of an ESRC Public Services Programme Fellowship 2007-2009\(^1\). In-depth interviews with current and past members of the Scottish Health and Community Care Committee, explored key factors influencing oversight behaviour. Interviews were also conducted with officials in the Scottish Parliament, House of Commons, Northern Ireland Assembly and National Assembly of Wales audit agency staff and civil servants in an effort gain a greater sense of perspective on oversight behaviour. In total twelve former Committee members, nine parliament/assembly officers, two audit agency officials, two civil servants and two interest group officers were interviewed.\(^2\)

**Parliaments and policy oversight in context**

It is generally assumed that the oversight capability of parliamentarians in the United Kingdom has been in long term decline, as power has been accrued by the executive. (Judge, 1981; Norton, 1981; Hansard Society, 2001) The monopolisation of knowledge over policy by the executive has been a significant factor in this process. The Westminster focused study of parliament literature certainly indicates a consensus over the prevalence of certain trends which have tended to reduce the importance of the scrutiny role. A supposed ‘golden age’ of Parliament between the 1830s and the 1867 electoral reforms, is said to have been the high point of influence in the political process for members outside of government. Since then the policy process has been increasingly dominated by the executive in the United Kingdom with similar trends frequently observable elsewhere in established democracies. The ‘golden age’ was marked by a capacity to hold government accountable across a range of issues. According to Rush (2001), a key factor for proponents of the ‘golden age’ notion, was that the problems of the period were of a type which allowed the average member of parliament to engage fully without recourse to detailed evidence and data. The latter half of the twentieth century saw the development of large scale public services with associated administrative complexities. Arguably this is particularly marked in the area of health policy which consumes nearly over 9% of United Kingdom GDP, which translates into around half of the budgets controlled by the devolved governments. Political issues have become more difficult to conceptualise and are consequently increasingly positioned beyond the policy competence of parliamentarians operating outside of government with its knowledge handling capacities.

In addition to a growing asymmetry between the knowledge of the back bench parliamentarian and government and consequent decline in capacity, there are also institutional developments to take account of in explaining declining inclination to conduct

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\(^2\) Ethical approval was granted by the University of Ulster.
effective oversight. The nineteenth century House of Commons was distinguished by relatively low levels of partisanship. Prior to 1886 Berrington (1967) concludes that ministers could rely on the support of opposition leaders to carry through legislation but after then backbench support from their own ‘side’ became a necessity. Subsequently party strength and discipline became more valuable to government. (Norton P., 2005) Party discipline has been secured through an appeal to members’ needs to develop careers in government. The conclusion is that the quality of parliamentary scrutiny of government has been in a long and fairly steep decline.

**Timing I - devolution and the transparency boom**

Before devolution in the United Kingdom health care policy had been subject to the oversight of the House of Commons Select Committee on Health\(^3\), a single group of parliamentarians dealing with health policy and management across the United Kingdom. On the basis of very simple calculation, four parliamentary committees should be able to conduct more oversight than one. In terms of scale the 11 members of the Westminster Committee have been joined by 28 elected representatives sitting on committees with responsibility for health policy in Northern Ireland, Scotland and Wales.

There is also the timing of the devolution programme to be considered in relation to oversight. Devolution of control over certain aspects of government to elected parliaments and assemblies in Scotland, Wales and Northern Ireland, coincided with a transparency boom where long campaigns for open access to the information used by governments, reached fruition in a series of reforms, which in the United Kingdom established levels of access arguably comparable to that available in the United States where this trend began. (Graham, 2002; Hood, 2006) It is logical to anticipate that the high tide of transparency left its mark on the architecture which created the devolved parliament/assemblies. This ought to be observable in the oversight behaviour of the relevant committees in the health policy field.

Ideas concerning the desirability of monitoring inputs, outputs and outcomes have been embedded in the respective administrations in Northern Ireland, Scotland and Wales for many years before devolution. The first ten years of the devolved governments in the United Kingdom were marked by the extent to which a high degree of public transparency has become the norm with the bulk of relevant public services evidence in the public domain and available to parliamentarians working in an oversight capacity outside government. The devolved governments also have access to skills and resources to support sophisticated monitoring and measurement systems.

\(^3\) Select committees have been organised on a departmental basis since 1979. (Drewry, 1985)
Timing II – devolution and the performance metrics boom

Devolution also coincided with a surge in the production of public services performance metrics and additionally the birth of web based information services, both of which may have contributed to the realisation of transparency values. The Labour Government elected in 1997 set off on a programme of public services regulatory reform which involved the creation of institutions to audit public services including the NHS. Since then the performance metrics system has been developing in the United Kingdom at a remarkable pace, such that is has been a defining feature of the New Labour era. In respect of health policy the Labour Government created what is almost certainly the most sophisticated public service performance measurement system anywhere in the world. As Pollitt et al (2008) note an entire industry has grown up around health service performance measurement, involving dozens of different organizations and hundreds of experts, including civil servants, epidemiologists, clinicians, statisticians, social scientists, health service managers and management consultants. Given the free access to such service information this has huge potential consequences for oversight conducted by parliamentarians.

Performance metrics, transparency and parliamentary oversight

Clinicians and NHS administrators enjoyed a monopoly over knowledge of health services performance, which government would access through their civil servants. Until the late 1980s on the other hand, a politician operating outside of the relevant government department would be required to do some significant work to acquire evidence which related to the performance of the health service and would almost certainly have relied to some extent on the cultivation of personal connections with NHS ‘insiders’. The MP of that era was by contemporary standards highly constrained in where they could find information. (Barker & Rush, 1970) In terms of being held to account by parliament, one might conclude that governments used to have easy. The range of media containing performance information on public services available to parliamentarians outside of government in the United Kingdom’s parliaments is now extensive with the worldwide web providing an alternative to the printed document or the conversation as a source of information, suggesting a capacity for enhanced quality of oversight.

In what is recognised as an era of high transparency, accessible, reliable and informative evidence, has given parliamentarians the opportunity to move in from the margins of the policy process where they had allegedly been beached for over a century. In the context of devolution there were initially good reasons therefore to believe that the Scottish Parliament,
where the work referred to in this paper began, constituted an ideal environment for inclining those members outside of government to use evidence such as performance metrics for oversight purposes. MSPs are elected through a system designed to discourage adversarial politics and dominance by party machines. MSPs also operate in an institution whose business is largely devoted to public services and carry out a comparatively high proportion of work in pre-planned committee sessions rather than the more spontaneous circumstances of a Westminster-like chamber. (Carman & Shephard, 2009)

In spite of the opportunities afforded, the evidence to confirm a reversal in the trend to executive dominance in politics produced by parliaments and assemblies invigorated by the transparency and evidence booms associated with devolution is thin. In general academic observers of the Scottish Parliament suggest that the balance of power inclines strongly in favour of ministers. (Arter, 2002; Shephard & Cairney, 2004; Shephard & Cairney, 2005; Cairney, 2006; Macmillan, 2009)

**Oversight of health policy compared**

The business of comparing oversight in four institutions is inevitably complex and there are a number of initial observations to be made regarding the roles of committees and their institutional ‘rights and responsibilities’ over the oversight of health policy in the four assemblies/parliaments. The House of Commons now has a total of 46 oversight committees (‘select committees’). The Health Select Committee examines the expenditure, administration and policy of the Department of Health (English) and its associated bodies. (House of Commons Health Committee, 2007-8) It has no legislative functions. It also has no formal input into the budget setting process, although in recent years has used an annual written questionnaire as the basis for witness interrogation sessions and to elicit an extensive written response (234 pages in 2007-8) from the Department of Health. (House of Commons Health Committee, 2007) Certain oversight activities which the House of Commons Select Committee on Health might conduct based on the health focused output of the National Audit Office, are in fact completed by the Public Accounts Committee. A division of responsibility means that the Public Accounts Committee does not consider the formulation or merits of policy but does have ‘rights’ over the examination of value for money studies of the economy, efficiency and effectiveness with which Government Departments including Health have used their resources. In any one year over 50 of these reports are adopted by the Public Accounts Committee for detailed examination. Of this number, only four were concerned with health in 2007-8.
In the National Assembly of Wales the Health, Wellbeing and Local Government Committee is one of five scrutiny (oversight) committees. (National Assembly of Wales, Health, Well Being and Local Government, 2007-8) The function of scrutiny committees is to examine the expenditure, administration and policy of the government and associated public bodies within their policy remit. There are also five legislation committees and nine other committees whose role is not deemed to involve either scrutiny or legislation. The Public Accounts and Finance Committees sit within this latter grouping. The Health, Wellbeing and Local Government Committee’s oversight remit constitutes almost 70% of the total Assembly Government budget. Like the House of Commons Health Committee the Welsh Committee has no legislative role. It does however, have a duty to consider and make recommendations on the Welsh National Assembly Draft Budget to the Finance Committee. As with the House of Commons, there is a similar potential overlap in responsibilities and rights to conduct oversight between the Health and Public Accounts Committees.

The Scottish Parliament has seven ‘subject’ committees with a hybrid role that involves both policy oversight and scrutiny of legislation. The Health and Sport Committee has sat since the beginning of Session 3 of the Scottish Parliament. (Scottish Parliament Health and Sport Committee, 2007-8) There are also seven ‘mandatory’ committees, a grouping which include both Audit and Finance. The Health and Sport Committee has a formal annual requirement to consider the budget and make a report to the Finance Committee. The Audit Committee rather than the Health and Sport Committee examine the output of the key public service regulatory agencies, although it can refer reports on to subject committees.

Within the Northern Ireland Assembly, the Committee for Health, Social Services and Public Safety has a multi-purpose role, unique amongst the four institutions considered in this paper, which includes ‘advice and assistance’ to the Minister. (Northern Ireland Assembly Health, Social Services and Public Safety Committee, 2007-8) The Committee undertakes a scrutiny, policy development and consultation role with respect to the Department of Health, Social Services and Public Safety and plays a key role in the consideration and development of legislation. The Northern Ireland Assembly has 11 departmental committees, six standing committees including Public Accounts and Audit plus two joint committees including an Education and Health Committee. The Public Accounts Committee has pursued a narrower role than its counterparts in Westminster, Scotland and Wales, which in 2007-8 restricted it to considering the reports prepared by the Auditor and Comptroller General. The Public Accounts Committee met only three times in 2007-8.

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4 Before reforms implemented in 2007 there were 19 hybrid legislative-oversight committees.
The House of Commons has by far the biggest staff budget and uses this to fund a Health Committee team that includes 8 committee staff including clerks with specialist knowledge of Parliamentary rules and practices and health policy specialists. In addition 19 special advisers were hired in 2007-8. The House of Commons Library can also provide more staff with specialist knowledge of health than is the case in the equivalent research departments in the devolved parliaments/assemblies. The numbers of staff and advisers are proportionately less in Northern Ireland, Wales and Scotland. The Scottish Parliament Health and Sport Committee by way of comparison, has a staff of three clerks with two members of the Scottish Parliament Information Centre dedicated to the health policy. A number of advisers will be used during the course of a parliamentary session, but this would not approach the figure of 19 advisers appointed by the House of Commons Select Committee on Health. Parliamentarians in all four institutions have the resource capacity to employ a researcher. There is however, clearly a major difference in the corporate support provided to committees conducting oversight of health policy. In discussing this issue one Scottish MSP expressed the view that ‘they spent all the money on the Parliament building at Hollyrood and have been so embarrassed by the bad press that anything like providing us with proper research support has been done on the cheap’.

Examining the data

On the face of it the devolution of powers to Northern Ireland, Wales and Scotland should mean health and community care policy is under more scrutiny than was the case pre – 1998. Four committees involving 39 elected representatives conduct oversight of government now, whereas health and community care policy in all four countries of the United Kingdom had previously been watched by just one committee comprising 11 members. With the intention of establishing some basic data on the current scale and circumstances of oversight, a content analysis of transcripts and minutes of the committees with responsibility for health and community care services was conducted. The parliamentary session 2007-8 was chosen for initial examination. The House of Commons Committee is solely concerned with health and community care, as is the case with the Northern Ireland committee. In Wales the relevant oversight committee is also responsible for ‘well being’ (public health more broadly defined than is usually the case elsewhere) and local government, while in Scotland the committee covers health (including community care) and sport. The figures for Northern Ireland are surprising, indicating that at 89 hours, roughly double the time is being spent on health care oversight than is the case in the other three parliaments/assemblies. (Little or no time was diverted to consider ‘public safety issues (fire services) in 2007-8. Neither the Welsh nor Scottish Committees spent more than 10 hours on the non-health matters in their remit, that is local government or sport, in 2007-8.
Each of the committees met between 24 and 34 times in 2007-8. Membership numbers ranged from eight to eleven members. While a committee can be programmed to meet, members attendance is not always so easy to secure. Attendance varied considerably from only 69% at Westminster to 93% in the Scottish parliament. The relative volume of oversight conducted by the four committees can be calculated for comparative purposes by multiplying membership x hours x attendance. On this basis the committees based in Welsh National Assembly, House of Commons and the Scottish Parliament score between 339 and 379 on the index, while the Northern Ireland Assembly achieves a high of 720. This finding encourages closer examination of the oversight activities conducted by the Northern Ireland Assembly Health Committee since it may be the case that the legislative and ministerial advice roles occupy high amounts of Committee time. Marnoch (2008) observed that the

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5 Estimate to be confirmed.
6 A single independent member
Scottish Parliament Health and Community Care Committee (predecessor to the current Health and Sport Committee) spent relatively time engaged on oversight in years where there was a heavy legislative programme under consideration.

When House of Commons and Scottish Parliament parliamentarians’ attendance records on health committees are compared over a number of years, the results would suggest there are significant differences in enthusiasm for committee work. Members of the Scottish Committee generally made an effort to attend most meetings. In Session 1 the average number of meetings attended by members of the Scottish Parliament Health and Community Care Committee was 86%, with the poorest attendee still achieving a record of 68%. In Session 2 the average attendance members was 94%, with the poorest attendee still managing 83% of meetings. The equivalent House of Commons Select Committee had an average attendance over four sessions between 2004 and 2008 of 73% but with significant instances of very poor attendance by a number of individuals noted. In 2007-8 for instance, four of its total membership during the year of 13, attended just 50% or less of meetings. (House of Commons Liaison Committee, 2009)

In line with the findings of Marnoch (2008) which suggested that in the Scottish Parliament committee members who belonged to the political party/parties in government and gained promotion to ministerial office had been less likely to ask performance metrics related questions about health policy – ‘minister in waiting syndrome’. Interviews with ex-ministers, committee members and parliamentary officials in Scotland confirmed the anticipated association between the intensity of oversight action on committee observed and the respective government or opposition party status of committee members. It was logical therefore to compare the respective percentage of the committees comprising members of political parties outside of government. The results show that Northern Irelands system of power sharing in government means that only the ‘accidental’ election of an independent MLA provided for a non-government committee membership of any proportion whatsoever. The Northern Ireland system of allocating ministries to currently five different political parties who secure seats in the Assembly, may mean that more observably aggressive oversight is conducted by members of the committee who belong to political parties other than that of the relevant minister. It is pertinent to note that while health and community care spending takes up over half the budget of the Northern Ireland government, control of the health portfolio was not a ‘prize’ sought by either of the two biggest political parties. Instead the DUP and Sinn Fein appear to have been complicit in giving the Health ministry to a nominee of the Ulster Unionists, the fourth biggest party in the Assembly. (Health services may be seen as a

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7 A GP who stood on the issue of opposition to a hospital closure.
‘poisoned chalice’). Comparing the other three parliaments/assemblies is more straightforward. Electoral numbers and executive formation outcomes mean that the Welsh committee has only 33% of its membership from outside the government parties, while in Scotland the figure is 63%. The House of Commons Health Committee currently stands in the middle with 46% of its membership comprising Conservatives, Liberal Democrats and an independent MP. On the basis of these figures it is likely that the Scottish committee will produce the most aggressive oversight of government policies. On the other hand Northern Ireland may prove to have produced a system which encourages adversarial behaviour in committee rather than cross party acquiescence over the conduct of health policy.

Another relevant factor in determining the respective quality of oversight is the ability of committees to call ministers and senior public servants to account in witness interrogation sessions. The figures in Table 1. show that there is a remarkably similar pattern with respect to the appearances of ministers, chief medical officers, NHS chief executives and heads of health departments before committee. The Welsh and Scottish committees cross examined ‘key witnesses’ on 13 and 12 occasions in session 2007-8, while the Northern Ireland and Westminster committees interrogated the same type of witness on 16 and 17 occasions. Any variations in the number of appearances by senior figures in the health policy field are likely to be explained by the nature of the oversight agenda being pursued in a particular session than by institutional factors. The data demonstrates that the oversight committees in the devolved parliaments/assemblies have a similar inclination and authority to call on star witnesses as the House of Commons Committee.

A significant difference emerged in the volume of oversight which takes place in relation to the health budget in the respective jurisdictions. The content analysis conducted on the House of Commons Health Committee showed that during 2007-8 a total of three hours was spent dealing with the public expenditure questionnaire which is related to the budget. The Northern Ireland Committee, in spite of spending by sitting in session for far longer than other committees, only devoted three hours to the budget. The Welsh Assembly Committee spent only one hour cross examining a ministerial witness and senior civil servants in relation to the draft budget. The Welsh Committee made a complaint to the effect that Standing Order 27.3 allows only 2 weeks for committees to consider the draft budget. They pointed out that this effectively limits scrutiny to just one Committee meeting, with minimal time to research and understand the implications of the budget. The timescale it was noted allows no time for committees to take evidence from stakeholders or others with relevant or wider expertise. Only the Scottish Parliament was in a position to conduct extensive

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8 Another GP standing on a ‘keep our hospital open’ single issue platform.
oversight as part of the annual budget process, spending a total of 11 hours cross examining ministers, senior civil servants and NHS staff. The Committee's report to the Finance Committee still contained a number of criticisms of the process, calling for more budgetary information to be produced by the Scottish Government and a longer timescale for budget scrutiny. (Scottish Parliament Health and Sport Committee, 2008)

**Discussion**

The evidence collected from the content analysis does suggest that a certain institutional functionality has been achieved in respect of the process of oversight in the three new institutions, which is an achievement of sorts. (Marnoch, 2003) There is of course a certain naivety in calculating the volume of oversight and concluding that more and hence ‘better watching’ happens post-devolution. The exercise carried out only provides a starting point in determining if government is subjected to more effective oversight, now health policy has been devolved to the parliaments and assemblies. This is because the quality of oversight being conducted by the committees established in the four parliaments /assemblies may vary. If for instance, the well staffed House of Commons Health Committee achieved a higher quality than the other three committees then as a consequence of devolution governments in Northern Ireland, Scotland and Wales are in consequence subjected to a less evidence informed oversight. Heald (2006) differentiates between the intrinsic value placed on transparency for its own sake and it’s fulfilling of an instrumental purpose in the sense of providing observers of government with the material to formulate searching questions which enhance democratic control. Without more evidence regards the quality of oversight behaviour as opposed to confirmation that oversight takes place, it is not possible to determine whether devolution has provided a better window for oversight. Marnoch (2008) concludes on the basis of interviews with key respondents in Scotland and elsewhere, that the quality of oversight is dependent on a number of identifiable factors including institutional rules on the scrutiny of audit agency reports, the economics of information research, the career enhancing value of alternative activities such as constituency work, enacting legislation and party manoeuvring and the knowledge handling capacity of the parliamentary institution including the relevant committee. This represents an agenda for future comparative research on oversight in Westminster and the devolved parliaments and assemblies.
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