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Internal coordination of social security in the United Kingdom

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Abstract:

Although social security is traditionally viewed as a highly centralized function in the UK, health care and long-term care have long been devolved to sub-state governments, an arrangement requiring extensive internal coordination agreements. This coordination has various objectives, including ensuring parity of benefits provision in Northern Ireland (where social assistance is devolved) and Great Britain (where it is centralized), securing financial reimbursements for cross-border health care provision, and determining responsibility and eligibility criteria for individuals in need of social care. Further devolution and decentralization of social security benefits over the past decade have made such coordination arrangements even more essential.

Keywords

United Kingdom, devolution, health care, long-term care, social assistance, internal coordination

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1. EXTENT OF DEVOLUTION AND DECENTRALIZATION

This article outlines the extent of devolution and decentralization in the areas of healthcare, long-term care, family allowances and social security in the United Kingdom, describes how competences of devolved and local governments are adjudicated in these areas, and summarizes the financial arrangements governing coordination of these schemes. Many of these functions are partly or wholly devolved, either to the UK's three devolved administrations in Scotland, Wales and Northern Ireland, or to local governments in England.

This first section outlines the specific areas of healthcare, long-term care, family allowances and social security that have been subject to devolution or decentralization, explaining the governance arrangements that have led to divergences in social protection schemes.

1.1 Territorial Divisions of Health and Social Security competences in the UK

Following affirmative votes in devolution referendums in Scotland (1997), Wales (1997), and Northern Ireland (1998), the UK Parliament passed three Acts that organized or re-established devolved government in the UK. These Acts and their successors¹ established three devolved legislatures which exercise varying powers and competences that had previously been held at the UK level. Devolution has transformed territorial politics in the United Kingdom, traditionally regarded as a pre-eminent example of a state that concentrated executive power at the central level.

The most significant area of devolved spending competence in Scotland and Wales is **health care**. Since the creation of the publicly-funded and operated National Health Service (NHS) in 1948 there has existed some territorial divergence: healthcare was administered in Scotland, Northern Ireland and Wales (from 1969) by separate health departments. Since 1999 however, this administrative devolution has been matched with significant political and legislative devolution. While the UK government retains responsibility for health care in England, the devolved executives have extensive powers; in particular over NHS funding, policy prioritization and administration.

Responsibility for funding and specifying arrangements for **long-term care** is also devolved. This has resulted in some notable differences in provision, including the amount that older people assessed as needing social care are required to pay towards costs (CASPeR 2016). Except for Northern Ireland, where long-term care is managed by regional boards, the devolved governments (and the UK government for England) have decentralized responsibility for delivering long-term care to the local level. For example, the *Care Act 2014* clarified and introduced new legal responsibilities and funding for English local authorities.

However, as in most other European countries, primary competence over welfare assistance and redistributive elements of major taxes and benefits have largely remained reserved to the UK level. Devolved competences apply mainly to the “distributive” services of health, education and social services (Lodge and Trench 2014). Social Security schemes across Great Britain (i.e. England, Scotland and Wales) are generally administered by the UK government’s Department for Work and Pensions. . The

department provides social security benefits, pensions, child maintenance and direct cash benefits to disabled people, carers and those with care needs.

The division of competence is different in Northern Ireland, where social security is not reserved to the UK in the *Northern Ireland Act 1998*. All social assistance schemes and family allowances are instead devolved and administered by the Social Security Agency, a division of the Northern Ireland Executive's Department for Communities. In practice, however, a parity principle has been adopted to maintain social security benefits at the same level as in Great Britain (see section 2 below). The system does however allow for some discretion, particularly in social security administration.

1.2 Recent Changes to Social Security devolution in the UK

Despite social security remaining a central competence in Great Britain, recent years have seen a partial but notable shift away from this highly centralized system of social security. Immediately following the narrow 'No' vote in the 2014 Scottish independence referendum, proposals brought forward by an investigative commission for new fiscal and welfare powers for Scotland were subsequently enacted by the *Scotland Act 2016*. This Act devolved 11 social security schemes to the Scottish Parliament, approximately 15% of all Scottish benefit spending. The devolved schemes relate to long-term care and social assistance. The Scottish Parliament has also been granted the power to make administrative changes to the UK government's Universal Credit and to vary the housing cost element. To administer these devolved responsibilities, the Scottish Government established a new agency, Social Security Scotland.

Although the Scottish Parliament has new powers to deviate from or replace UK benefits, this can only be done within the terms set out in legislation. For example, the Act pre-defines who would be entitled to the Scottish Government Carers' benefit (McEwen 2015). There also remain significant financial constraints, because funds transferred to the Scottish budget for social security devolution will vary according to changes in per person spending on these benefits in the rest of the UK. Any deviation from UK policy must therefore be funded by increased taxes or reallocations from other budgets.

The UK's *Welfare Reform Act 2012* also transferred limited competences to Scotland, Wales and Northern Ireland and to local governments in England. The Act abolished some discretionary elements of the social fund, namely Crisis Loans that provided emergency payments, and Community Care Grants that assisted people leaving residential or institutional care. These schemes were replaced by schemes operated by English local authorities termed Local Welfare Provision (National Audit Office 2016).

The *Local Government Finance Act 2012* also replaced the national system of Council Tax Benefit (a means-tested rebate of local property tax) with localized schemes in England. The Independent Living Fund, which provided cash payments to disabled people with support needs, was also closed in 2015 and transferred to local government in England or to the devolved governments in Wales and Scotland.

This complex and asymmetric picture is summarized in table 1.

TABLE 1: EXTENT OF DEVOLUTION AND DECENTRALIZATION

	UK Country			
	Scotland	Northern Ireland	Wales	England (local authorities)
Health Care	Devolved	Devolved	Devolved	-
Long-term Care	Devolved	Devolved	Devolved	Local Authority responsibilities
Family Allowances	Reserved	Devolved (parity principle)	Reserved	-
Social Assistance	<i>Reserved, except for some devolution of social security schemes</i>	Devolved (parity principle)	Reserved although some discretionary schemes devolved	Some localization

2. ADJUDICATION OF COMPETENCE OF REGIONAL OR LOCAL AUTHORITY

This second section describes how jurisdictional responsibility for social security schemes that have been devolved or decentralized are determined for individuals. It also identifies the policy frameworks and intergovernmental protocols that coordinate cross-border interactions relating to healthcare and social security.

2.1 Health care

To illustrate coordination arrangements for UK health care, we use the cases of Wales (where health care is a devolved competence) and England (where it remains a UK government responsibility). Since they share the longest border of the UK countries with significant internal migration and commuting, health care provision requires the most extensive coordination arrangements. Similar cross-border arrangements are found elsewhere in the UK.

The current legal framework for the Welsh NHS is set out in the *National Health Service (Wales) Act 2006*, which sets out Welsh Ministers' responsibilities and establishes seven *Local Health Boards*, the regional administrative units responsible for the delivery of healthcare in Wales. Local Health Boards are responsible for persons usually resident in their area² and for certain categories of children who are from their area but are placed elsewhere (for example, children in care).

The Welsh Government's *Responsible Body Guidance for the NHS in Wales* (2013) establishes guidance in designating the body that is responsible for an individual's health care where relatively unusual circumstances exist.³ In general, the primary arbiter of a patient's residence is the patient themselves. If a person is unable to give an address, a patient's residence will be taken as the location of the unit currently providing treatment. This safeguard extends to persons with no fixed residence.

Although the funding and administration of healthcare is devolved to Wales, the prison service is not. Prisoners detained in any Welsh prison are 'usually resident' for the period

of their detention regardless of their original domicile, and following a recent prison construction programme, an increasing number of English prisoners are housed in Wales. Although the UK Government makes annual transfers to the Welsh Government to compensate for the cost of prisoner healthcare (for example, £3.4 million in 2012-13); these transfers have generally not met the full cost of treating inmates (BBC 2014).

Provision and coordination of cross-border healthcare services are governed by an agreement between the Chief Executive of the NHS in Wales and the Chief Executive of the NHS Commissioning Board in England. This *Protocol for Cross-Border Healthcare Services* aims to ensure smooth and efficient interactions either side of the England-Wales border.

In 2016, approximately 15,000 Welsh residents were registered with a family doctor in England, and around 21,000 English residents were registered in Wales (Watkins 2016). According to the agreed protocol, Local Health Boards in Wales retain legal responsibility for the Welsh-resident population who are registered with a doctor in England. These arrangements are *not* however mirrored for English residents. England's NHS is not only less centralized than in Wales, but the internal 'purchaser' and 'provider' functions are separated. Clinical Commissioning Groups (CCGs) are networks of English doctors' practices that commission health care services for their registered patients from hospitals and other providers. For English residents registered in Wales, although legal responsibility is retained by the English CCG responsible for the resident's area the Welsh Local Health Board is responsible for securing healthcare services for those individuals.

A stated objective of the cross-border health care protocol is that there should be no financial shortfall on the part of any LHB or CCG to provide healthcare services to the other country's residents by adjusting finances between the Welsh Government and the UK Department of Health.

The UK's *National Health Service Act 2006* (as amended by the *Health and Social Care Act 2012* – mainly applying to England only) places a duty on the NHS England Commissioning Board to consider the possible impact of its commissioning decisions on health services provision for Welsh residents who live near the English border. There is currently no similar provision in Welsh legislation.

Because of Wales' relatively low population density, many highly-specialized healthcare services are provided by English hospitals. These services are commissioned by the *Welsh Health Specialised Services Committee*, a joint committee of the seven LHBs in Wales. For most types of specialized care, service level agreements and contracts are in place with English hospitals to treat Welsh patients. In 2015, the committee managed 34 healthcare contracts with English providers worth £100 million.

2.2 Long-term care

Responsibility over long-term care, including social services, is also devolved to Wales, Scotland and Northern Ireland. Separate legislation outlines the framework for the delivery of social services and sets out the duties of local governments. In England, Scotland and Wales, 'ordinary residence' is the key determinant of which local authority

has a duty to assess and meet the care and support needs of individuals. Under Section 39 of the *Care Act 2014*, a local authority is only required to meet the needs of an adult who is ‘ordinarily resident’ in their area. In cases where a carer provides for individuals living in different local authority areas, the Act requires local authorities to co-operate and includes arrangements for joint assessments and support planning. Ordinary residence can be acquired as soon as the person moves – if voluntary and for settled purposes: there is no minimum period for individuals to be considered ‘ordinarily resident’ in an area.

The *Care and Support (Disputes between Local Authorities) Regulations 2014* set out procedures for local authorities when disputes arise. The local authority supporting the adult/carers on the date that the dispute arises must continue to do so until the dispute is resolved. When disputes are not settled, local authorities can apply for a determination by the UK minister. A similar legislative framework exists for Wales, as set out in the *Social Services and Well-being (Wales) Act 2014*. In Scotland, the *Social Work (Scotland) Act 1968* details the responsibilities of local authorities in Scotland, and the Scottish Government occasionally issues revised guidance. Scottish policy with regards to ‘ordinary residence’ mirrors that of other UK jurisdictions (Scottish Government 2016).

Local authorities and the individual concerned may occasionally decide in favour of placement in a care home in a different country of the UK. The legal frameworks governing cross-border placements are set out in Schedule 1 of the *Care Act 2014* and accompanying statutory guidance. When an authority places an adult into residential care in another country of the UK, *responsibility* for the adult is not transferred. Ministers of

the UK department or the devolved governments have responsibility for determining disputes between local authorities, depending on the country in which the individual is ordinarily resident.

2.3 Social Assistance

Northern Ireland

Social assistance was first devolved to the Northern Ireland Parliament by the *Government of Ireland Act 1920*, and in more recent decades, *the Northern Ireland Act 1998* restated this position (Birrell & Gray 2014). The relevant Northern Ireland Minister is required to ‘consult’ the responsible UK welfare minister, ‘with a view to securing that, to the extent agreed between them, the legislation... provides single systems of social security, child support and pensions for the United Kingdom (Section 87 (1) *Northern Ireland Act 1998*).

Despite legislative competence, Northern Ireland’s weaker economic base meant the cost of providing social protection equal to the rest of the UK from local revenues alone has always been unsustainable (Simpson 2015). Financial subsidies from the UK Treasury have sustained Northern Ireland’s social assistance programmes since 1926, and this “financial imperative” of Treasury subsidies has significantly reduced any scope for “ideological or operational divergence” (McKeever 2016: 136). The current UK position is not only that Northern Ireland should not be subsidized to pay enhanced benefits to GB schemes, but that any savings from social security programmes in Northern Ireland would accrue to the UK government (Birrell & Gray 2014). Consequently, uniformity with GB

provision has been “all but absolute, with parity seen to serve Northern Ireland’s financial interests” (Simpson 2015: 253).

This parity of provision is operationalized by means of separate, but identical Northern Ireland legislation (Heenan & Birrell 2006) that “with minor exceptions, provide identical cash benefits under near-identical conditions” (Simpson, 2015: 253). Intergovernmental coordination over adjudication of competence is essential to such a system. This coordination takes the form of several statutory and non-statutory agreements that provide a framework for coordination and reciprocity in social assistance and child support between Northern Ireland and Great Britain.

Reciprocity in social security benefits between Northern Ireland and Great Britain is facilitated by the UK’s *Social Security (Northern Ireland Reciprocal Arrangements) Regulations 2016* and Northern Ireland’s corresponding *Social Security (Great Britain Reciprocal Arrangements) Regulations (Northern Ireland) 2016*. These provide mutual recognition of social security claims for individuals moving between Northern Ireland and Great Britain, specifically in relation to Employment and Support Allowance and the Personal Independence Payment. This reciprocity avoids the requirement that individuals moving between the two jurisdictions make a new claim for assistance and/or undergo a new Work Capability Assessment (a test introduced by the *Welfare Reform Act 2012* to determine whether social assistance claimants are entitled to sickness benefits). Reciprocity in child support arrangements is also governed by regulation.

The legal requirement for consultation between the NI and GB welfare ministers is operationalized at an organisational level through intergovernmental memorandums, the most recent being the *Concordat between the Department for Work and Pensions and the Northern Ireland Department for Communities (2018)*. This Concordat specifies how parity between GB and NI social assistance schemes is maintained between officials in both governments and specifies a large number of work areas that are subject to joint working, including policy development, drafting legislation, and exchange of data.

Social security provisions do occasionally diverge in minor ways. In Northern Ireland, Birrell & Gray (2014) note at least two *de minimis* divergences from full parity, namely small variations in service provision for unemployed or economically inactive claimants, and amendments to the UK Government's *Welfare Reform Act 2009* to reflect the different availability and cost of childcare in Northern Ireland. More recent (and substantial) divergences were triggered by the tightening of social security assistance programmes by the UK's *Welfare Reform Act 2012*, legislation which caused significant political turmoil between the two largest parties in Northern Ireland. The 2015 'Fresh Start' Agreement permitted Northern Ireland to provide transitional arrangements that would mitigate the impact of certain cuts and modify the highest level of sanctions against claimants who fail to meet their requirements (McKeever 2016), in particular where a claimant refuses a job offer. Because this divergence was negotiated to be beyond the parity principle, Northern Ireland's block grant was not offset to pay for this mitigation.

Scotland

Since the passage of the *Social Security (Scotland) Act 2018*, coordination mechanisms between Scotland and the rest of the UK are being established by regulations of the Scottish Government's newly established agency, Social Security Scotland. Residency and cross-border issues are of particular importance, because unlike Northern Ireland where maintenance of parity has been the primary objective, diverging from UK social security arrangements was a central focus of intergovernmental discussions following the Scottish independence referendum (McKeever 2016). The new system will allow for enhanced benefits and liberal operational variations from the UK model, so that incentives may emerge for individual claimants to transfer their residency. However, as several Scottish 'top-up' benefits will be applied to pre-existing UK assistance schemes (especially Universal Credit), Bell notes the "considerable overlaps between the devolved and reserved benefits, which will add significantly to the complexity of an already complex system" and "require considerable resources and very close co-operation between [the UK Department of Work and Pensions] and the [Scottish Social Security Agency]" (Bell 2016: 8).

3. FINANCIAL ARRANGEMENTS

The devolved governments of Wales, Scotland and Northern Ireland are primarily financed through an annual block grant from the UK government. The size of the block grant depends on previous spending levels, with year-to-year changes determined by a population-based share of spending by the UK government on comparable services in England that are devolved to Wales, Scotland and Northern Ireland. Funding arrangements are described in the HM Treasury's 'Statement of Funding Policy'.

Over the last decade, successive Acts have devolved new tax competences to Scotland and Wales. The *Scotland Act 2016* devolved most income tax revenues to the Scottish Government, and the *Wales Act 2017* devolved approximately half of the income tax revenues collected in Wales to the Welsh Government. Even after fiscal devolution, however, the devolved governments will be heavily reliant on fiscal decisions taken by the UK government. The distribution formula used to calculate the block grant transfers for the devolved governments, known as the ‘Barnett formula’, has been regularly criticized for not reflecting the relative spending needs in the devolved territories (e.g. Independent Commission on Funding & Finance for Wales 2010).

Spending by local authorities in England, Wales and Scotland is financed by general grants from central government, revenues from local property taxes and redistributed revenues from local business property taxes.

The funding of healthcare provided to residents of one country living in another is determined by bilateral cross-border agreements. For primary care (which includes family doctor services, dentistry and ophthalmic services), there is no funding flow between the countries. In the case of secondary care services provided to patients registered with a doctor across the border, a net funding transfer is agreed annually between the Department of Health and the Welsh Government. This transfer amounted to approximately £6 million to the Welsh government in 2015, determined by the ‘net

import' of English residents to Wales and multiplied by spend per resident (House of Commons Welsh Affairs Committee 2015).

When secondary and tertiary services are commissioned in England for patients residing in Wales with a doctor in Wales, the responsible Local Health Board (or the Welsh Health Specialised Services Committee) transfers funding to the English NHS providers, either under contractual or non-contractual arrangements. For flows of services in the other direction, Welsh LHBs charge the English Clinical Commissioning Groups (CCGs) for the activity based on local calculated costs (House of Commons Welsh Affairs Committee 2015).

Separate bilateral agreements have been made between the four administrations of the UK to address the question of which government bears the cost of NHS funded nursing care required for individuals placed cross-border into a care home. In the event of cross-border placements between England and Scotland or between England and Northern Ireland (in either direction), the health service of the country of the first authority will be responsible for nursing costs. When a cross-border placement between England and Wales (in either direction) is made, the second authority's health service will be responsible for the costs of nursing care.

4. CONCLUSION

As the UK has moved away from a mostly centralized model of provision, coordination arrangements have been required to reflect growing powers at devolved and local levels

in the field of social security. This article has outlined the arrangements for cross-border coordination over decentralized policy areas, including reimbursement arrangements for health care and determinations of which government retains responsibility for individuals in need of adult social care. These arrangements and protocols have generally resulted from bilateral agreements between the UK and devolved governments rather than uniform principles, reflecting the rather ad-hoc nature of devolution in the UK. Scotland's newly devolved powers over social security benefits and decentralization of some UK government schemes have made such coordination arrangements even more essential.

Notes

1. Scotland Acts 1998 and 2016; Government of Wales Acts 1998 and 2006; Wales Acts 2014 and 2017; and Northern Ireland Act 1998
2. Regulation 2(2) of the Local Health Boards (Directed Functions) (Wales) Regulations 2009.
3. In England, similar rules are set out for Clinical Commissioning Groups in the guidance document 'Who Pays? Determining Responsibility for Payment to Providers', the legal framework for which is provided by the Health and Social Care Act 2012 and in accompanying regulations.

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