



Towards a Welsh health law: devolution, divergence and values[†]

John Harrington, Barbara Hughes-Moore and Erin Thomas¹

Cardiff University

Correspondence email: harringtonj3@cardiff.ac.uk

ABSTRACT

COVID-19 and Brexit have given political impetus to re-examine Wales's place within the United Kingdom's devolution settlement. Health has been a key site for divergence in law and policy as between the administrations in Cardiff and London. In light of these contests, and the longer-running trends in devolution, this article considers whether a distinct 'Welsh' health law has now emerged. We examine the constitutional context and the range of sources for this new legal field. We argue that a set of values can be identified through an attentive reading of the legislative output of the Welsh Parliament, through reflection on the policy development of health in Wales, through the devolution process. While accepting that these are varied and heterogeneous, these values are as much an expression of universal ethical goals as they are of any delineable Welsh essence. No mere summation of positive law, these values allow one to define a distinctive realm of Welsh health law, have the potential to act as an interpretative lens for analysing law and policy flowing from Westminster, and could potentially act as a value structure for further Welsh legislation.

Keywords: devolution; divergence; values; Welsh jurisdiction; COVID-19; health law; healthcare; Coronavirus Act 2020; NHS; Brexit.

INTRODUCTION

The health landscape of Wales and the United Kingdom (UK) is changing. Pre-existing tensions and divisions over Brexit and wider constitutional issues of devolution and governance have been illuminated and exacerbated by COVID-19.² At the onset of the pandemic, the Welsh, Scottish and Northern Irish administrations and

[†] First published in NILQ COVID-19 Supplement 72(S1) (2021) 62–90.

¹ Respectively Professor of Global Health Law, Lecturer in Law and ESRC Doctoral Researcher, School of Law and Politics, Cardiff University. We are indebted to Matt Watkins for detailed comments on earlier drafts. Thanks also to Abbie-Rose Hampton, Huw Pritchard and Charlie Sinden. The usual disclaimer applies. Research for this article was made possible by a Welsh Government Sêr Cymru award.

² J Bradbury, 'Welsh devolution and the union: reform debates after Brexit' (2021) 92 *Political Quarterly* 125; G Evans 'Devolution and Covid-19: towards a "new normal" in the Territorial Constitution?' (2021) (1) *Public Law* 19-27.

the UK Government, for England, committed to respond in a closely coordinated fashion,³ in line with the Sewel Convention and the Memorandum of Understanding. However, by May 2020 each began to develop policy independently.⁴ Legal divergence has been matched by political dispute, with Cardiff and Edinburgh claiming they were ignored and outflanked, and Westminster complaining of deviation for its own sake.⁵ The pandemic has undoubtedly made the existence of an increasingly distinct Welsh ‘health space’ visible to the wider public. It has also highlighted the contested and uneven nature of devolution, dramatising the defence of legislative autonomy in Wales and Scotland and resultant push-back by an actively pro-union UK Government.⁶ These vectors traverse the adjustment to Britain’s departure from the European Union (EU), with all three devolved administrations denying consent to the EU (Withdrawal Agreement) Act 2020. The destination of powers repatriated from Brussels, and the scope of the UK-wide internal market, are significant for the health competencies of devolved administrations.

Divergence in health law and policy across the UK is not a new phenomenon. It has been in train, steadily if often unremarked, since the implementation of devolution in 1998. In Wales, distinctive measures on organ donation, tobacco control and the structure of the health service, for example, have attracted the attention of scholars in law, ethics and health policy.⁷ Such reviews have generally been discrete, however, focusing on a specific measure and contextualising it with reference to, say, English or Scottish equivalents. Less attention has been directed to the emerging ensemble of law and regulation as a whole. The contemporaneous challenges of COVID-19 and Brexit provide us with the occasion for just such an encompassing review.

We take up this challenge, inquiring into the nature and scope of health law in Wales and considering its prospects for further development. We first provide a brief chronology of Welsh devolution through the lens of health and contextualised by COVID-19. We subsequently outline sources of Welsh health law and explore emergent areas in which a distinct Welsh application and interpretation is visible, focusing on key initiatives like organ donation, tobacco control and the structure of NHS Wales. Welsh health law ‘exists’, we argue,

3 Coronavirus Act 2020.

4 ‘Covid: has devolution helped or hampered coronavirus response?’ (*BBC News*, 28 October 2020).

5 W Hayward, *Lockdown Wales: How Covid-19 Tested Wales* (Seren 2020).

6 M Kettle, ‘Johnson’s last-minute bid to save the union can’t undo years of neglect’ *The Guardian* (London, 25 January 2021).

7 S Greer and D Rowland (eds), *Devolving Policy, Diverging Values? The Values of the United Kingdom’s National Health Services* (Nuffield Trust 2007).

not only as a distinctive corpus of legal rules and policies, but also as a set of distinct challenges related to its constitutional frame and technical complexity, as well as the unique population health problems which it is deployed to address. Moreover, we will also suggest briefly that the distinctiveness of Welsh health law also rests on moral and political values which can be identified in current Welsh practice, in historical forms of health solidarity in Wales, and in the common British and European inheritance. Our conclusion draws out briefly some implications for health law scholarship in a devolved UK of the developments we have identified in the case of Wales.

HEALTH AND THE DEVOLUTION SETTLEMENT

Welsh legislative autonomy has evolved since 1998, from administrative to executive devolution, and from measures to primary law-making. Its pre-history can be traced to the start of the twentieth century. At that time, local authorities and the Welsh Board of Health were generally responsible for health, but there existed no distinct 'Welsh' decision-making level, *per se*. When the National Health Service (NHS) was established across the UK in 1948, newly nationalised voluntary and local authority hospitals were managed by regional boards, including one for Wales. The latter was directly accountable to the central government in London.⁸ As the political founder of the Service, Aneurin Bevan, put it, 'when a bed-pan is dropped on a hospital floor, its noise should resound in the Palace of Westminster'.⁹ No official Cabinet-level position representing Welsh interests existed until the creation of the Welsh Office and the position of Secretary of State for Wales in 1964, who was given responsibility for health in 1969.¹⁰

Policy determined in Westminster did not always reflect local needs, and the Welsh Office was devolved in administrative capacity only. Key reform initiatives like the Griffiths Report challenging the lack of NHS management structures (1983) and the 'internal market' among general practitioners and NHS hospitals (1991) were simply adopted and implemented in Wales as elsewhere. The advent of devolution came in 1998, following a (narrow) victory for the 'Yes' campaign in

8 P Michael, *Public Health in Wales (1800–2000): A Brief History* (Welsh Government 2008) 20.

9 Cited in P Nairne, 'Parliamentary control and accountability' in R Maxwell and N Weaver (eds), *Public Participation in Health: Towards a Clearer View* (The King's Fund 1984) 33–51.

10 D Miers and D Lambert, 'Law making in Wales: Wales legislation online' (2002) Public Law 663.

the 1997 referendum.¹¹ Devolution was seen by the Labour party, long dominant in Wales, as an opportunity to restore the non-market ethos of Bevan's NHS and to put 'clear red water' between it and the New Labour and Conservative Governments in London.¹² Under the keystone Government of Wales Act 1998 (GOWA 1998) health was deemed an area of conferred power through a process of executive, rather than legislative, devolution. This meant the newly created National Assembly for Wales could pass secondary legislation on health, but only after seeking the UK Parliament's approval on a case-by-case basis. Even then the doctrine of parliamentary sovereignty allowed (and still allows) Westminster to pass overriding legislation on exclusively devolved matters. Functions of the Secretary of State for Wales were transferred to the Assembly.¹³ Tax powers were not included among these competencies.¹⁴

The Government of Wales Act 2006 (GOWA 2006) gave the Assembly primary law-making powers for the first time, allowing it to pass legislation ('Assembly Measures') on certain prescribed areas and establishing health as a non-reserved power. A 2011 referendum asked voters whether the Assembly should have direct legislative powers over 20 areas including health and education, as well as tax-raising powers: 63.5% voted yes on a relatively low turnout of 35.2%.¹⁵ The Commission on Devolution in Wales 2012 recommended further expanding primary law-making and fiscal powers,¹⁶ resulting in the Wales Act 2017. The Act extended Wales's fiscal powers, increasing the Welsh Government's borrowing limits and enabling it to set Welsh rates of income tax as well as moving Welsh devolution to a 'reserved powers' model, conceding legislative power to Cardiff in all but a series of enumerated areas.¹⁷ This strengthening of devolution was reflected

11 The creation of a Welsh Assembly was approved by 50.3% in the 1997 referendum, representing a 50.1% turnout. N Duclos, 'The 1997 devolution referendums in Scotland and Wales' (2006) *French Journal of British Studies* 12.

12 D S Moon, 'Rhetoric and policy learning: on Rhodri Morgan's "clear red water" and "made in Wales" health policies' (2013) 28 *Public Policy and Administration* 306.

13 Transfer of Function Orders 1999; GOWA 1998, s 22(2), sch 2.

14 GOWA 1998, sch 2.

15 R Scully, 'Welsh referendum analysis: Wales "united in clear vote"' (*BBC News*, 4 March 2011).

16 Commission on Devolution in Wales, 'Empowerment and responsibility: devolving financial powers to Wales' (HM Treasury/Wales Office 2012); 'Empowerment and Responsibility: Legislative Powers to Strengthen Wales' (Office of the Secretary of State for Wales 2014).

17 Wales Act 2017, s 7A.

in the Assembly renaming itself Senedd Cymru (the Welsh Parliament) in 2020.¹⁸

It is clear from the foregoing that how we define health affects the scope of devolution. A narrower definition, focused on clinical medicine and orthodox public health interventions may concede more scope to the areas reserved to Westminster, limiting the action of Welsh authorities. Turning to the relevant legislation, schedule 2 of GOWA 1998 referred to '[h]ealth and health services'. This was preserved and elaborated on by GOWA 2006, which describes health as 'physical or mental health' and encompasses 'health and emotional well-being', 'social and economic well-being' and citizens' rights.¹⁹ A similarly broad understanding of health is warranted by article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) which the UK has ratified.²⁰ General Comment 14 of the United Nations (UN) Committee on Economic Social and Cultural Rights defines the right broadly to include not only healthcare and standard disease control measures, but also underlying social and environmental determinants like housing and clean air. This inclusive approach is underwritten by the current popularity of 'Health in All Policies', acknowledging the influence that laws, actions and interventions outside the direct remit of the health sector have for the promotion of health.²¹ Though not explicitly referenced in the legislation, GOWA 2006's definition of health and wellbeing is certainly consistent with such an approach.

It is important, however, to note that the scope of devolution in this area is not solely determined by definitions, but also by practice and policy. Reserved powers in ostensibly non-health areas may limit Cardiff's capacity to legislate for health. For example, prison policy is reserved to Westminster, but the Welsh Government manages prisoner healthcare.²² As a result, there is no clean break, but a 'jagged edge' which causes difficulties in law and practice.²³ This unevenness is not simply a matter of definitions and overlapping competences. It is also a site of contestation between Cardiff and Westminster, as we explore in the next section with reference to the challenges of the recent coronavirus pandemic and the UK's exit from the EU.

18 Senedd and Elections (Wales) Act 2020, s 2.

19 GOWA 2006, sch 5, matter 15.10 (a)–(f).

20 General Comment 14 of the Committee on Economic, Social and Cultural Rights.

21 E Ollila, 'Health in all policies: from rhetoric to action' (2011) 39 *Scandinavian Journal of Public Health* 11.

22 T Enggist et al (eds), *Prisons and Health* (WHO Regional Office for Europe 2014) 2.

23 R Jones and R W Jones, 'Justice at the jagged edge' (Wales Governance Centre 2019).

PULLING AWAY AND PUSHING BACK: COVID-19 AND BREXIT

COVID-19 has exposed the significance, and potential inadequacy, of current devolution arrangements.²⁴ In March 2020, Westminster passed the Coronavirus Act 2020, a collaborative effort which conferred new powers on devolved administrations.²⁵ A collective decision to institute a UK-wide lockdown was made on 23 March, though increasing divergence in timing and scope emerged over the following months.²⁶ The Government in Cardiff generally took a more cautious approach than its London counterpart, implementing a slower exit from the original lockdown in spring 2020 and a stricter ‘firebreak’ in Autumn 2020.²⁷ Most conspicuous in UK-wide media were restrictions on the movement of people into and out of Wales, which re-established a frontier with England that has not existed since mediaeval times.

Although civil service contacts, as between Cardiff, Belfast, Edinburgh and London, worked well throughout the crisis, intergovernmental relations were notably strained at the highest level.²⁸ UK Prime Minister Boris Johnson refrained from all communication with Mark Drakeford and Nicola Sturgeon, Welsh and Scottish First Ministers, in the key months between May and September 2020.²⁹ Rhetorical styles differed too, with Drakeford positioning himself, in Laura McAllister’s words, as ‘the political antithesis of Johnson’.³⁰ An early rise in popularity for the Welsh Labour Government was tempered by the UK Government’s successful vaccine procurement strategy.³¹ Labour’s subsequent success in the Senedd elections of May 2021 has been attributed to the cautious approach to COVID-19 taken by Drakeford and former Health Minister Vaughan Gething, and to Wales’s vaccine

24 Evans (n 2 above).

25 Coronavirus Act 2020, ss 11–13, ss 37–38, s 52, ss 87–88, s 90. For example, devolved ministers are empowered to temporarily close educational establishments.

26 Health Protection (Coronavirus) (Wales) Regulations 2020.

27 ‘National coronavirus firebreak to be introduced in Wales on Friday’ (Welsh Government, 19 October 2020).

28 Hayward (n 5 above) ch 8.

29 Ibid.

30 L McAllister, ‘Covid-19: how have our political leaders performed in the face of such a crisis?’ (*Wales Online*, 4 July 2020).

31 ‘Covid-19: Wales has more confidence in Welsh Gov than England in UK Gov – study’ (*Nation Cymru*, 21 June 2020); M Savage, ‘Boris Johnson’s poll lead over Labour boosted by Covid vaccine rollout’ *The Guardian* (London, 27 February 2021).

roll-out programme which has been among the broadest and fastest in the world.³²

Growing awareness of devolution and its applicability to health has, however, been accompanied by uncertainty as to which rules apply.³³ Much of the Welsh population get their news from London-based sources which often neglect to indicate that measures imposed by Westminster are specific to England only.³⁴ This potential for confusion threatens rule of law values concerning the 'knowability' of applicable criminal law and the capacity of citizens to hold governments to account. It also potentially jeopardises public health by undermining the even application of lockdown measures, which is essential to interrupting the spread of infection. This is not merely a matter of information and legal certainty, however. It also gestures to the current weakness of the Welsh public sphere and the absence of a robust civil society which can scrutinise and challenge Senedd Cymru and the Welsh Government.³⁵ This is not only an internal political weakness. The elision of Wales and England has also been reinforced by Westminster's increased deployment of the symbols and language of British identity and unity. Downing Street's COVID-19 briefings have been marked by the prominence of the UK flag and undifferentiated references to 'our nation', 'Britain' and 'our country'.³⁶

This scene of contest and confusion has been exacerbated as a result of the UK's departure from the EU. If COVID-19 has promoted centrifugal tendencies between the devolved administrations and the UK Government, then by contrast the Internal Market Act 2020 may be the agent of recentralisation of power to Westminster. Passed to ensure the barrier-free movement of goods across the UK following the Brexit transition period, the Act mandates that the internal market be guided by principles of mutual recognition and non-discrimination. Legal and political scholars have identified the Act's troubling implications for pro-health policies under devolution.³⁷ Notably, no exception to these principles is permitted on public health grounds. Accordingly,

32 'Covid vaccination rollout: how is Wales leading the UK and the world?' (*BBC News*, 28 May 2021).

33 Hayward (n 5 above) ch 9.

34 'For Wales, see England? The UK media and devolution' (*IWA*, 25 September 2020).

35 R Rumdul, 'Critical friend or absent partner? Institutional and organisational barriers to the development of regional civil society' (2016) 23 *European Urban and Regional Studies* 848.

36 For a further example, see 'Eight-storey union flag planned for Cardiff UK-government building' (*BBC News*, 30 June 2021). h

37 N McEwen, 'The Internal Market Bill: implications for devolution' (*Centre for Constitutional Change*, 11 September 2020); T Lock et al, 'Rights and devolution after Brexit' (University of Edinburgh Working Paper 2018).

goods complying with English standards cannot be prevented from sale in Wales on the basis that Cardiff has legislated for a higher level of consumer protection. In other words, free trade is preserved within the UK by restricting the power of devolved governments to raise environmental and public health standards, as has been done in Wales regarding the single-use plastics and the pricing of alcohol.³⁸

The administration in Wales refused to consent to the Act, invoking the process set out in Standing Order 29.³⁹ This restates the Sewel Convention, according to which the UK Government is obliged to obtain the consent of the devolved administrations in any case where it seeks to legislate in an area of non-reserved competence. Westminster ignored the Convention, passing the Act over the protests of the devolved governments. Consistent with its recentralising politics, it is effectively privileging the doctrine of parliamentary sovereignty over any more nuanced understanding of the contemporary UK constitution. In response, the Counsel General for Wales sought judicial review, arguing *inter alia* that the Act ‘impliedly ... repeal[s] areas of the Senedd’s legislative competence’ by preventing the imposition of legislative requirements on the sale of goods in Wales that are additional to requirements elsewhere in the internal market.⁴⁰ Labelling the Act ‘a constitutional overhaul’ which curtails protections once enjoyed as part of the EU, he predicted that the UK will cut standards and use the Act ‘to force the devolveds to follow suit’.⁴¹ On 19 April 2021, the High Court refused permission to continue the Counsel General’s case, which it called ‘premature’, as neither party had exercised powers under the Act.⁴² However, the Court of Appeal subsequently granted permission to appeal due to the ‘important issues of principle going to the constitutional relationship between the Senedd and the Parliament of the UK’ raised by the applicants.⁴³

38 British Medical Association, ‘Parliamentary briefing: UK Internal Market Bill, House of Commons Committee Stage’ (September 2020). See further, T Sokol, ‘Public health emergencies and export restrictions: solidarity and a common approach or disintegration of the internal market?’ (2020) 57 *Common Market Law Review* 1819.

39 J Miles MS, *Legislative Consent Memorandum: United Kingdom Internal Market Bill* (25 September 2020) [84]; Scottish Government, *Legislative Consent Memorandum: United Kingdom Internal Market Bill* (September 2020) [117].

40 *R (on the application of The Counsel General for Wales) v The Secretary of State for Business, Energy and Industrial Strategy* [2021] EWHC 950 (Admin), Case No: CO/188/2021.

41 J Miles, ‘Why Wales must resist the Westminster power-grab, and how to do it’ (*Wales Governance Centre*, 21 January 2021); Miles (n 39 above).

42 *R v The Secretary of State for Business, Energy and Industrial Strategy* (n 40 above) [37] and [6].

43 M Antoniw MS, ‘Written statement: legal challenge to the UK Internal Market Act 2020 – update’ (29 June 2021).

Our discussion of health law in Wales in this section has emphasised variability over time. On the whole, competences have expanded, though the recent push-back from Westminster may see some recuperation of powers *de facto*, if not *de jure*. To a certain extent Wales currently takes a middle way between the separatist tendencies of Scottish and (Northern) Irish nationalists on the one hand, and the assertive centralisation of English conservatives on the other.⁴⁴ Though the outcome of this contest cannot be predicted, it is clear that the discrete arrangements of Wales, Scotland, Northern Ireland and England have already given rise to four separate health systems premised on divergence, as well as convergence, asymmetry as well as replication. They are tied together by the law of a sovereign Parliament whose authority can and at times does override theirs. To contextualise this internal unevenness, we now examine the disparate sources of health law in Wales.

SOURCES OF WELSH HEALTH LAW

Law in Wales generally manifests in four ways: legislation passed by the Senedd, laws of general UK-wide application passed at Westminster, European and international law, and the binding common law of England and Wales. As will be seen, these principles and rules cannot be ordered into a neat hierarchy without remainder. Rather, Welsh health law is better regarded in its complexity as a ‘spaghetti bowl’ of norms derived from multivarious, sometimes conflicting, sources.

Welsh legislation

Wales has its own health law framework, comprised of primary and secondary legislation enacted by Senedd Cymru. Primary legislation (‘Acts of the Senedd’) has the same legal force in Wales as Westminster laws.⁴⁵ Welsh health laws include the Social Services and Well-being (Wales) Act 2014 and the Public Health (Wales) Act 2017. The former imposes a duty to promote the wellbeing of those who need care and support, emphasising outcomes and partnerships in care; the latter requires public bodies to carry out health impact assessments and imposes a duty upon Welsh ministers to make regulations about the circumstances and ways in which they carry them out. As noted above, all health-related matters are devolved to Wales, except for those explicitly reserved to Westminster, including abortion and xenotransplantation.⁴⁶ Given its significance for criminal law, mental

44 M Kettle, ‘Only a full devolution reset can stop the UK splintering apart’ *The Guardian* (London, 30 June 2021).

45 Permitted by GOWA 2006, pt 4.

46 Wales Act 2017, sch 7A, s J1, s J2.

capacity continues to be governed by the UK-wide legislation, related regulations and Code of Practice. By contrast, while the Mental Health Act 1983 as amended in 2007 applies across England and Wales, mental health policy is almost wholly devolved.⁴⁷ Thus, while the conditions under which people can be lawfully detained or compelled into assessment are not devolved, care quality and the operation of Mental Health Review Tribunals are.⁴⁸

The legislative process is initiated when a ‘Public Bill’ is introduced by the Welsh Government, a Member of the Senedd, or a Senedd Committee.⁴⁹ The Bill undergoes a four-stage process under Standing Order 26, including consideration of general principles by the Senedd in plenary and by its Health, Social Care and Sport Committee, line-by-line scrutiny, a discussion of proposed amendments, and a final vote. Secondary legislation is laid down by ministers as statutory instruments and regulations.⁵⁰ The latter may augment UK, as well as Welsh, legislation. The Welsh Government is now subject to a duty to codify discrete areas of legislation, including health. This will involve a consolidation and rational ordering, though not a substantive rewriting, of all applicable statutes, both Welsh and UK-wide.⁵¹

Welsh legislation is subject to limitation and challenge in several ways. As we have discussed, it may be repealed or abrogated by subsequent Westminster statutes, though this is subject to the Sewel Convention which requires Cardiff’s consent as a political matter.⁵² Equally, devolved legislation must be repealed if found to exceed legislative competence by the Supreme Court on referral by the UK Attorney General or the Counsel General for Wales,⁵³ as happened with the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill 2013.⁵⁴ Finally, all new Welsh legislation must be pre-certified

47 With the exception of detaining restricted patients, mental health policy and services are fully devolved to Wales. See ‘Commission on Justice in Wales: supplementary evidence from the Minister for Health and Social Services’ (Welsh Government 2019) 3.

48 B Hannigan, ‘Observations from a small country: mental health policy, services and nursing in Wales’ (2021) *Health, Economy, Policy and Law* 1, 5.

49 ‘Guide to the legislative process’ (Senedd Cymru, 28 May 2021).

50 Eg Coronavirus Act 2020 (Commencement No 1) (Wales) Regulations 2020.

51 Legislation (Wales) Act 2019, s 1.

52 Inserted into GOWA 2006, s 107(6), by Wales Act 2017, s 2.

53 This was the case with the Local Government Byelaws (Wales) Bill which the Supreme Court ultimately held was within the Senedd’s competence: *Local Government Byelaws (Wales) Bill 2012 – Reference by the Attorney General for England and Wales* [2012] UKSC 53.

54 *Recovery of Medical Costs for Asbestos Diseases (Wales) Bill – Reference by the Counsel General for Wales* [2015] UKSC 3.

as compatible with the European Convention on Human Rights (ECHR)⁵⁵ and may be challenged under the Human Rights Act 1998 (HRA 1998) on the same basis as UK legislation.⁵⁶ Unlike the latter, however, Welsh laws can be struck down if they contravene Convention rights.⁵⁷ This additional check has been positively embraced by the Welsh Government, which opposed Westminster's 2016 proposal to withdraw from the ECHR and replace the HRA 1998 with a, 'British' Bill of Rights.⁵⁸

Local authorities are empowered by Welsh legislation to plan, commission and provide frontline health services for their communities.⁵⁹ They also play an active role in addressing social determinants of health through functions relating to local transport, education and housing.⁶⁰ This is achieved through the passage of health-related byelaws (eg for the preservation of green spaces) and through policy development.⁶¹ In particular the Well-being of Future Generations (Wales) Act (WBFGA) 2015 established public services boards (PSBs) within local authorities which have a statutory duty to carry out wellbeing assessments and formulate health and social care plans. The city of Cardiff PSB, for example, has acted to tackle air pollution by incentivising public transport use and cycling.⁶²

UK legislation

The Westminster Parliament remains an important source of health legislation in Wales. Pre-1998 statutes have been carried over, though they are subject to amendment and repeal in areas of devolved competence such as health. Thus, the Children Act 1989 still applies

55 As with the Human Transplantation (Wales) Bill: Explanatory Memorandum incorporating the Regulatory Impact Assessment and Explanatory Notes (Welsh Government, 25 June 2013) [174]; Wales Office, Pre-Legislative Scrutiny of the Proposed National Assembly for Wales (Legislative Competence) (Health and Health Services) Order 2 (January 2011) [32].

56 GOWA 2006, ss 108A(1)–(2)(e).

57 T G Watkin, 'Human rights from the perspective of devolution in Wales' (British Academy Briefing 2016) 5.

58 House of Lords Select Committee, 'The UK, the EU and a British Bill of Rights, chapter 8: the impact of repealing the Human Rights Act in the devolved nations' (HRA0001) [159].

59 Local Government (Wales) Act 1994, sch 9, as amended by the Local Government (Wales) Measure 2011. See *Improving Health in Wales: A Plan for the NHS with its Partners* (National Assembly for Wales 2001) ch 4.

60 *Health in Wales: Chief Medical Officer's Report 2001/2002* (National Assembly for Wales 2002) 48.

61 Cardiff Council Environmental Scrutiny Committee, 'Report: cycling in Cardiff's parks' (March 2012) KF1, 6; Local Government Byelaws (Wales) Act 2012.

62 *Cardiff Well-being Plan 2018–2023: Annual Report 2019/20* (Cardiff Public Service Board 2020) 19.

subject to changes made by the Social Services and Well-being (Wales) Act 2014, which creates a statutory duty to assess the care and support needs of children and replaces the ‘medical model’ language of the UK Act, which determined need on specific bases of age and disability, with an ‘impairment neutral’ model, namely, ‘people who need care and support’.⁶³ Post-1998 legislation of UK-wide application, such as the Health and Social Care Act 2012 and the Mental Capacity Act 2005, is a further source.⁶⁴ As noted above, the ongoing judicial review of the Internal Market Act 2020 will determine whether such legislation can be challenged for infringing on devolved competences. Should the application succeed, the Supreme Court would still only be able to advise on interpretation, as it cannot overturn an Act of the UK Parliament.⁶⁵ Under the Memorandum of Understanding between the constituent territories of the UK, consultations are to be held with the devolved governments on legislation that will apply across the UK, as was the case with the HRA 1998 and the Equality Act 2010, and on devolved matters and related policy fields regardless of whether they entail legislative change.⁶⁶ In addition, it is worth noting that the Welsh Affairs Committee at Westminster scrutinises Wales Office activity and UK proposals impacting Wales. In 2010 it inquired into the Senedd’s legislative competence in relation to a change in organ donation rules discussed more fully in the next section.⁶⁷ Welsh Members of Parliament in the House of Commons can vote on health legislation regardless of its territorial scope of application.

European and international law

As the UK is no longer an EU member state, section 108(6) GOWA 2006, which required Acts of the Senedd to comply with EU law obligations, now has no legal effect.⁶⁸ New EU law has ceased to be binding in the UK following the Brexit transition period, but a snapshot of ‘retained EU Law’ as it applied on 31 December 2020 has been converted into domestic law.⁶⁹ Examples of this include UK Health and Safety (Consultation with Employees) Regulations 1996, which derived from the EU’s Health and Safety Framework Directive

63 Social Services and Well-being (Wales) Act 2014, s 3. See L Clements, ‘*The Social Services & Well-being (Wales) Act 2014: an overview*’ (January 2021).

64 Westminster can also pass legislation for Wales only, like the Transport (Wales) Act 2006.

65 See the Counsel General’s challenge of the Internal Market Act, discussed above.

66 Devolution Guidance Note 1 Common Working Arrangements [23]–[28].

67 House of Commons Select Committee, ‘*Organ donation (legislative competence)*’ (*Parliament.uk*, 4 April 2011).

68 EU Withdrawal Act 2020.

69 EU (Withdrawal) Act 2018, ss 2–4.

89/391/EEC, and the Control of Asbestos Regulations 2012 drawing on EU Directive 2009/148/EC.⁷⁰ British courts may have regard to decisions of the Court of Justice of the European Union (CJEU) so far as they are relevant or may aid in interpreting retained EU law in domestic cases, though they are not bound to do so.⁷¹ However, the CJEU retains a time-limited jurisdiction in relation to the rights of EU citizens residing in the UK, which include rights to access healthcare and social security.⁷² These are enforced through a preliminary reference procedure, by which UK courts seek guidance on the interpretation of citizens' rights in cases commencing within eight years of the transition period.⁷³

International law relevant to health enters Welsh law in three ways. First, by direct incorporation into applicable UK law. Treaties may be domesticated in full, for example the ECHR through the HRA 1998, or in part, for example elements of the Convention on the Rights of Persons with Disabilities (CRPD) through section 6 Equality Act 2010.⁷⁴ Second, by direct incorporation through Senedd laws, for example the UN Convention on the Rights of the Child (CRC), article 24 of which confers the right to the highest attainable health standards, was integrated in Wales through the Rights of Children and Young Persons (Wales) Measure 2011. Third, by direct incorporation into Welsh law through secondary legislation, including the Equality Act (Wales) Regulations 2011. Additional to this are treaties ratified by the UK which it, and by extension the Welsh Government, is obliged to implement, even though their provisions are not part of domestic law, for example article 12 ICESCR which enshrines the right to the highest attainable standard of health for all. In addition, international law has proved an important source for Welsh policy and law-making in more indirect ways. For example, the Action on Disability Protocol embeds the CRC and optional protocols into Welsh law through a requirement being placed on specified bodies to have regard to the Convention when carrying out functions.⁷⁵

70 Health and Safety (Amendment) (EU Exit) Regulations 2018 (SI 2018/1370).

71 EU (Withdrawal) Act 2018, s 6.

72 Pt 2 of the European Withdrawal Agreement 2020. See T Hervey, N Miernik and J C Murphy, 'How is part two of the Withdrawal Agreement (citizens' rights) enforceable in the courts?' (*EU Law Analysis*, 28 May 2020).

73 European Withdrawal Agreement, art 158(1). Brought into UK law by the European Union (Withdrawal) Act 2018, s 7C, the UK legal effect will be the same as under the Treaty on the Functioning of the European Union, art 267.

74 The definition of 'disability' in the Equality Act 2010 overlaps with but is narrower than that in the CRPD.

75 Welsh Government, 'Action on disability: the right to independent living – framework and action plan' (2019) 7.

Professional and advisory bodies

Professional licensing and regulation of health workers in Wales remains a matter for UK-wide bodies, including the General Medical Council and the Nursing and Midwifery Council.⁷⁶ While not sources of law, statutory bodies like these and others help to shape and influence policy and governance by setting norms and standards for professional conduct. They enforce these standards through disciplinary powers, which are capable of review in the Court of Appeal and can result in practitioners being struck off the register.⁷⁷ Advisory bodies, professional associations and ‘think tanks’ operating at UK level, like the Nuffield Council on Bioethics, the Faculty of Public Health and the Nuffield Trust, provide expert input into policy and legislation affecting Wales, whether made in Cardiff or London. Thus, the Welsh Government pledged to invest an additional £295 million in NHS Wales in 2015–2016, after a Nuffield Trust report highlighted the threat to service provision resulting from Westminster’s austerity policies.⁷⁸ This is complemented by the work of Wales-based bodies, whether official, such as the COVID-19 Moral and Ethical Guidance for Wales Advisory Group, which provides policymakers with COVID-related ethical advice, or civil society, such as Cymru Well Wales, a public and voluntary sector collective.⁷⁹ More indirectly, values and standards promoted by NHS Wales and Public Health Wales (PHW) may be taken up within the terms of employment contracts and, thus, be the focus of common law decisions on the quality of care or practices around the end of life, for example.

Common law and the ‘Welsh jurisdiction’

Although legislation is increasingly important in health law generally,⁸⁰ case law remains central to areas such as consent, negligence and end-of-life decision-making, as well as to statutory interpretation.⁸¹ In

76 Others include the General Dental Council, the General Chiropractic Council, the General Optical Council and the Hearing Aid Council.

77 See, for example, *General Medical Council v Bawa-Garba* [2018] EWHC 76.

78 A Roberts and A Chatsworth, ‘A decade of austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26’ (Nuffield Trust 2014); ‘Written statement – together for health’ (Welsh Government, 25 March 2015). The report was commissioned by the Welsh Government.

79 PHW, *ACE Aware Wales*; Welsh Government, ‘COVID-19 Moral and Ethical Guidance for Wales Advisory Group’ (CMEAG-Wales).

80 M Brazier and J Miola, ‘Bye-bye Bolam: a medical litigation revolution?’ (2000) 8(1) *Medical Law Review* 85–114.

81 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583. See S W Chan and others, ‘Montgomery and informed consent: where are we now?’ (*British Medical Journal*, 12 May 2017). *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1998] UKHL 24; *HL v UK* [2004] ECHR 471.

our case, this remains the common law of England and Wales, which has been unified since 1535. The legal profession and judiciary are similarly fused across the two countries. In the present context it is worth noting, moreover, that legal commentators and the judiciary have treated law as being more or less one across all three jurisdictions, namely, Scotland, Northern Ireland, and England and Wales. Thus, leading Scots cases from *Hunter v Hanley*⁸² to the recent *Montgomery v Lanarkshire Health Board*,⁸³ are treated as leading precedents for the whole UK.

This is starting to change, however. Whereas in 1999 Lord Bingham suggested that the prospect of a distinct Welsh common law was ‘improbable’, current and future trends render it more likely.⁸⁴ Thus, a distinct Wales court circuit has developed, alongside the practice of hearing Welsh cases in the Administrative Court in Wales⁸⁵ and the establishment of a Mental Health Review Tribunal for Wales, already mentioned.⁸⁶ All courts, common to England and Wales, or specific to the latter are faced with significant challenges in interpreting and applying applicable health law, given the complexity of sources. Where legislation from either Cardiff or London governs a field or an issue exclusively, its application will be unproblematic. But, as we have seen, this is rarely the case. Often it will be necessary to construe legislation of diverse origin together, as is the case with the Mental Health (Wales) Measure 2010 and the (UK) Mental Health Act 2007, for example. Moreover, the prior question of whether a field is exclusively governed by a specific law is always itself a matter of interpretation, as with more or less obvious examples of the ‘jagged edge’ between devolved and non-devolved responsibilities. These difficulties pose a significant impediment to the determination of the rights and responsibilities of health workers, patients and citizens, and thus to the effective delivery of care and public health more generally. Wales is alone in the UK in lacking a legal jurisdiction under which to determine these questions, and to allow the development of a coherent and intelligible body of law on the implementation of its devolved law-making powers in

82 *Hunter v Hanley* [1955] ScotCS CSIH_2.

83 *Montgomery v Lanarkshire Health Board* [2015] UKSC 1.

84 T Bingham, ‘The common law: past, present and future’ (1999) 25(1) Commonwealth Law Bulletin 18–30, 25.

85 R Evans, ‘Devolution and the Administration of Justice’ (Lord Callaghan Memorial Lecture 2010), cited in H Pritchard, ‘Revisiting legal Wales’ (2019) *Edinburgh Law Review* 23, 123–130, 126.

86 For a powerful critique of liberal approaches to health law and ethics, see Commission on Devolution in Wales, ‘Empowerment and responsibility: devolving financial powers to Wales’ (HM Treasury/Wales Office 2012).

health.⁸⁷ While this raises rule of law issues of general concern, it is worth recalling that health law raises especially significant matters of life and death, essential liberties, and meaning and value in individual lives. Realisation of these formal values is threatened by growth of heterogeneous norm-creation and interpretation without clear oversight by practitioners, academics and the judiciary.⁸⁸

Such concerns have led to calls for the creation of a separate Welsh jurisdiction.⁸⁹ While initially reluctant, the Welsh Government added its support in a 2021 policy statement *Reforming the Union*.⁹⁰ Academic commentators concur on the basis that Wales already possesses two of the three widely accepted prerequisites for a separate legal jurisdiction, namely, a defined territory and a distinct body of law, though not yet a structure of courts and legal institutions.⁹¹ More importantly, the complexity of law in Wales requires the development of legal sub-disciplines and a body of specialist practitioners that can only come about through a distinct jurisdiction. The creation of the Administrative Court for Wales points the way in this regard,⁹² as does the appointment of Lord Lloyd Jones to the Supreme Court on the explicit basis that a judge with Welsh expertise was needed to interpret post-devolution law.⁹³

LEGISLATING FOR HEALTH

Health law in Wales is increasingly distinctive from that in England and the rest of the UK, not only as regards its sources, but also in its content. This is significantly due to the activity of the legislator in Cardiff, seeking to maximise use of its limited, if expanding, devolved powers. Health is of particular political importance in this regard, given the close association of the Labour Party, long dominant in Wales,

87 E Llwyd, N Evans and A F Jones, 'Developing a Welsh legal jurisdiction' (Plaid Cymru 2010).

88 J Montgomery, 'Law and the demoralisation of medicine' (2005) 26 *Legal Studies* 185.

89 Commission on Justice in Wales, 'Report: justice in Wales for the people of Wales' (2019) 498–500.

90 Evidence submitted by the Welsh Government to the Commission on Devolution in Wales, Welsh Government Evidence Paper WG17658 (18 February 2013) 2. 'Reforming our Union: shared governance in the UK' (Welsh Government, June 2021).

91 J Williams, 'The emerging need for a Welsh jurisdiction' (2010) *IWA Agenda* 42, 38–40, 38.

92 *R (Bridges) v Chief Constable of South Wales Police* [2020] EWCA Civ 1058, heard in Wales, was the first UK case to consider the compliance of automated facial recognition technology with ECHR rights.

93 'First Welsh Supreme Court judge is appointed' (*BBC News*, 21 July 2017).

with the NHS.⁹⁴ Reform of healthcare delivery has, thus, been a key focus since devolution. Admittedly, prior to 1998, the Welsh Office had discretion regarding the organisation of the health service in Wales.⁹⁵ However, ultimate policymaking power remained at Westminster and the service was in truth no more than a 'bilingual' copy of its English counterpart, adopting market-oriented reforms under both Conservative administrations from 1979 to 1997.⁹⁶ These neo-liberal reforms were undone soon after devolution, in Wales as in Scotland.⁹⁷ Instead, Cardiff sought to integrate health and local government,⁹⁸ promoting participation and decentralisation by vesting the running of the NHS in 22 local health boards which were subject to a process of democratic health planning through reinvigorated Community Health Councils.⁹⁹ This innovation was subsequently curbed as a result of the 2003 Wanless Report, which highlighted the failure of Wales's reformed NHS to deliver improvements in the quality of care and access to it.¹⁰⁰ Since 2009, therefore, the recentralised Welsh NHS has been comprised of seven health boards and three NHS trusts, collectively responsible for providing primary and secondary care, along with public and mental health, accountable directly to the Welsh Government. Though abrogating the more thoroughly democratic orientation of the first phase of devolution, this recentralisation was subsequently seen as enabling Wales's relative success in implementing lockdowns and rolling out vaccine delivery during the COVID-19 pandemic.¹⁰¹

In public health, devolved Welsh administrations have sought to deal with the country's distinctive health burden, much of it a legacy of industrialisation and deindustrialisation in urban areas. High-profile

94 T Smith and E Babbington, 'Devolution: a map of divergence in the NHS' (2006) 1 *British Medical Journal Health and Policy Review* 9.

95 For example, the Health Authorities Act 1995 enabled the Welsh Secretary to vary, abolish or create health authorities. This power was used in 1996 to disband Wales's nine authorities and replace them with five. See Health (Wales) Act 2003.

96 S Greer, 'Devolution and health in the UK: policy and its lessons since 1998' (2016) 118 *British Medical Bulletin* 16.

97 *Ibid* 21–22.

98 S Greer, 'Four way bet: how devolution has led to four different models for the NHS' (*The Constitution Unit* 2004) 4.

99 'Improving health in Wales: structural change in the NHS in Wales' (National Assembly of Wales 2001). Community health councils will be replaced in 2023 by a single national Citizen Voice Body, shifting away from localism and towards (English) centralization: Health and Social Care (Quality and Engagement) (Wales) Act 2020, s 23, pt 4.

100 D Wanless, 'The review of health and social care in Wales' (Welsh Assembly Government 2003).

101 H Gye, 'Wales has triumphed on vaccine rollout because of small supply buffer and centralised NHS, First Minister says' (*i*, 15 June 2021).

initiatives have been directed at reducing tobacco use and increasing organ donation. Thus, smoking restrictions in all workplaces were introduced in 2005,¹⁰² following earlier UK Labour Government White Papers.¹⁰³ The ban was extended to enclosed public spaces, as well as school grounds, hospital sites, public playgrounds and children's football matches, in an effort to reduce the harmful effects of second-hand smoke.¹⁰⁴ The sale of nicotine products (including e-cigarettes) to children under 18 has also been proscribed, though attempts to instate a general ban on smoking in cars and vaping failed to secure sufficient support among legislators.¹⁰⁵ These initiatives were intended to 'de-normalise smoking behaviour and reduce the chances of children and young people taking up smoking', a goal which the Welsh Government affirmed was underpinned by children's right to health *inter alia* enshrined under the UN CRC.¹⁰⁶ On the whole, a more openly interventionist and frankly paternalist public health strategy has prevailed, in the face of objections from libertarian commentators and campaigners who sought to defend the right to smoke in terms of individual autonomy, an argument which apparently has less traction in Labour-dominated Cardiff than at Conservative-led Westminster.¹⁰⁷

The rhetorical privileging of collective over individual interests also marked the reform of post-mortem organ donation in Wales. Thus, where the UK-wide Human Tissue Act 2004 operated a system of express consent, evidenced by a person registering to be an organ donor, the Human Transplantation (Wales) Act 2013 enshrines the principle of deemed consent, under which all who die are assumed to have agreed to their organs being donated unless they object.¹⁰⁸ The Act imposes a duty on Welsh ministers to increase public knowledge about consent and is premised on claims that countries with 'opt-outs' have higher donation rates.¹⁰⁹ Indeed, Wales has the highest organ

102 Action on Smoking and Health, 'Advance media briefing: government consultation on smoking in workplaces' (17 June 2005).

103 *Smoking Kills* (Department of Health 1998); *Secondhand Smoke, Public Health* (Department of Health 2004).

104 Smoke-free Premises etc (Wales) Regulations 2007; Public Health (Wales) Act 2017; Smoke-free Premises and Vehicles (Wales) Regulations 2020.

105 Public Health (Wales) Act 2017, pt 1, s 1(3)(d); 'E-cigarette ban proposals defeated in Welsh Assembly' (*ITV News*, 16 March 2016).

106 Welsh Government, 'Smoke-free law: guidance on the chances from March 2021' (22 December 2020).

107 Eg smokers' lobby group Forest, see 'Wales starts public smoking ban' (*BBC News*, 2 April 2007).

108 Human Transplantation (Wales) Act 2013, ss 1–4.

109 A Abadie and S Gay, 'The impact of presumed consent legislation on cadaveric organ donation: a cross-country study' (2006) 25 *Journal of Health Economics* 599.

consent rate of all four of the UK's constituent territories, though there has been little overall change in the number of suitable donors or successful transplants.¹¹⁰ Again, this public health measure was adopted in the face of pro-autonomy arguments, with the Welsh Government justifying its reforms on the basis that Wales is 'a nation known for altruism, generosity and thought for others'.¹¹¹ This sense of exceptionalism has dissipated somewhat since then given that similar opt-out systems have now been implemented in England and Scotland, respectively, and one is currently proposed for Northern Ireland.¹¹²

Our discussion of selected initiatives suggests the emergence of a substantive corpus of Welsh health law. We have also picked out some features and trends as regards the values that informed these developments. These varied over time and issue. Thus, while solidarity was consistently emphasised, values of participation rose and fell in influence. There has undeniably been an expressive element to this legislation, with health policy reform used to signal both the fact that Wales is now self-governing in this area and that it pursues more 'virtuous' policies. In sum, the embrace of collectivism in the absence of participation has privileged the central (now Welsh) state as the lead actor in health, rather than either private companies, local government, or citizens themselves. This stance came to wider public attention during the COVID-19 pandemic, as we discussed above, with First Minister Drakeford claiming his Government's aim had been to keep Welsh people 'safe'.¹¹³

In practice, as we have noted, these specific initiatives have met with only modest success. A history of inequality, poverty and marginalisation, in both urban and rural areas, means that much of the population continues to suffer from relatively poor underlying health. These enduring features were reckoned to be one cause of Wales's high COVID-19 death rate, and indeed government policy and decision-

110 J Parsons, 'Ensuring appropriate assessment of deemed consent in Wales' (2019) 45 *Journal of Medical Ethics* 210.

111 D J Dallimore et al, 'Media content analysis of the introduction of a "soft opt-out" system of organ donation in Wales 2015–17' (2019) 22 *Health Expectations* 485; *Proposals for Legislation on Organ and Tissue Donation* (Welsh Government White Paper WG13956, 2011) 1.

112 The Organ Donation (Deemed Consent) Act 2019, also known as Max and Keira's Law; Human Tissue (Authorisation) (Scotland) Act 2019; Northern Ireland Department of Health, 'Public consultation document on the introduction of a statutory opt-out system for organ donation for Northern Ireland' (11 December 2020).

113 Welsh Government, 'Written statement: keeping Wales safe from coronavirus' (Welsh Government, 22 September 2020).

making have not gone without criticism in this regard.¹¹⁴ Viewed in terms of effectiveness, then, Welsh policy might be considered ‘different’, but not necessarily ‘better’ when compared with that in other parts of the UK.¹¹⁵ Ironically perhaps, this adds a further justification for taking Welsh health law seriously as such. In ways not always allowed for by political speech writers, the concrete institutional and epidemiological problems which law and policy seeks to reshape are particular to Wales. If health law is to be more than simply an exercise in closed doctrinal reasoning, it needs to be developed and critiqued with reference to these practical effects and their specific national and sub-national contexts. Accepting that, in the next and penultimate section, we widen our review, considering features of historic and contemporary practice which indicate a discrete, though by no means unique, set of concerns and values for health law in Wales.

VALUES FOR A WELSH HEALTH LAW

Values matter to the descriptive study of policy and law. Political scientists, studying divergence and convergence as between the four UK health systems, recognise that ‘different systems make different choices because policymakers differ in the meaning and priorities they assign to different values’.¹¹⁶ Scholars of health law have been less willing to embrace value pluralism as an explanatory variable in their accounts. Developing in symbiosis with modern bioethics, health law has instead been described with reference to universally valid principles cast in fairly abstract terms. It is ideally timeless and placeless, with actual variation more likely to be attributed to day-to-day political tactics and constitutional struggles. Against this, however, one of us has argued elsewhere that health law in the decades following the Second World War was *British* in a significant sense: permeated by locally specific cultural forms and assumptions about the purpose of the welfare state and the NHS, and the nature of clinical practice, for

114 J Halliday, ‘“It’s heartbreaking”: inequality reaps high Covid toll in south Wales valleys’ *The Guardian* (London, 8 February 2021); ‘Covid-19: UK had one of Europe’s highest excess death rates in under 65s last year’ (*British Medical Journal*, 23 March 2021). See also Hayward (n 5 above).

115 E St.Denny, ‘What does it mean for public policy to be “made in Wales”?’ (*LSE BPP*, 19 October 2016).

116 S L Greer and D Rowland, ‘Why discuss values in health? Why now?’ in S L Greer and D Rowland (eds), *Devolving Policy, Diverging Values? The Values of the United Kingdom’s National Health Services* (Nuffield Trust 2008) 13.

example.¹¹⁷ In pointing towards *Welsh* values as an additional indicator of distinctiveness, we are not thereby elevating the merely provincial in place of the universal. Rather, we are drawing out the analytical implications of the relativisation of Anglo-Britain as the container and source of health law across the UK. Given this constitutionally, legislatively and (in part) jurisdictionally plural landscape, an adequate account of health law in the UK requires us to attend to the values immanent in the institutional histories and professional cultures of the devolved nations. That is, of course, an onerous and open-ended task well beyond the scope of the present article. What we offer here, in the case of Wales, is a very brief indication of some distinct values and their sources in law, practice and social history. Before doing so, it is important to clarify that we are not claiming that some Welsh essence expresses itself in health law. Even if such a quality could be defined, it would be unlikely to find a way through the admixture of applicable norms deriving from a variety of national, British and international sources. Moreover, as will be seen, the values themselves can also be traced to these diverse sources, and they are shared to varying degrees by many other countries.

Solidarity

Mutual concern and assistance have repeatedly been picked out as distinctive Welsh values, particularly by Labour leaders since devolution. Former First Minister Rhodri Morgan, for example, referred to solidarity as ‘the powerful glue’ of Welsh society.¹¹⁸ This talk is no doubt strategic and performative, striving rhetorically to create a distinct polity within the terms of one party, and has properly been met with scepticism by some academic commentators.¹¹⁹ Nonetheless, it does build on a tradition with historical warrant, albeit one which is more pluralistic than that evoked for party political advantage. Central to most accounts are the Welsh origins, not just of the founder of the NHS, Aneurin Bevan, but of its institutional form. As we have noted, prior to 1948, healthcare was provided across the

117 J Harrington, *Towards a Rhetoric of Medical Law* (Routledge 2017). The enduring importance of the NHS as a marker of Britishness is borne out in current debates about the terms of any future reunification of Ireland: see S Breen, ‘Poll: NHS could be crucial in border poll with support for united Ireland and the Union running neck-and-neck’ *Belfast Telegraph* (Belfast, 25 October 2020).

118 Rhodri Morgan, ‘[Clear red water](#)’ (speech to the National Centre for Public Policy Swansea, 11 December 2002)

119 Moon (n 12 above). See also, D Evans, K Smith and H Williams, ‘Introduction: the Welsh way’, in D Evans, K Smith and H Williams (eds), *The Welsh Way: Essays on Neoliberalism and Devolution* (Parthian 2021) 1–24.

UK through a patchwork of charitable, local authority and private facilities.¹²⁰ This largely restricted the best and most comprehensive care to the wealthy. The South Wales coalfield was a partial exception with its network of medical aid societies. Pooling the subscriptions of miners, societies employed general practitioners to deliver primary care for all, as documented in A J Cronin's bestselling 1937 novel *The Citadel*.¹²¹ Alongside them, miners' institutes, hubs of community life in South Wales, catered to wider welfare needs by promoting sport and leisure activities.¹²² For Cronin, this health infrastructure provided the blueprint for socialised medicine across the UK.¹²³ Bevan, who had himself chaired the Tredegar Workmen's Medical Aid Society, claimed that: 'all I am doing is extending to the entire population of Britain the benefits we had in Tredegar for a generation or more. We are going to "Tredegar-ize" you.'¹²⁴

Solidarity was not limited to the coalfield or to groups traditionally seen as bearers of Welshness. Thus, nineteenth-century Irish immigrants, faced with sectarian hostility from the local population, established 'Hibernian societies' to provide mutual aid for healthcare and welfare more generally.¹²⁵ The 1980s saw a Wales-focused campaign to challenge prejudice and discrimination relating to the HIV/AIDS pandemic and to promote inclusive and rational public health strategies in response.¹²⁶ While wider alliances were not easily formed, they were able to build on the solidarity shown by the 'Lesbians and Gays Support the Miners' group in South Wales during the national strike of 1984.¹²⁷ Though women (and children) benefited from the medical aid societies, the latter were largely led and funded by men. There is nonetheless an important history of women's collective action for health down to the present day. Thus, in the nineteenth and early twentieth centuries, middle-class organisations, like the Ladies Samaritan Fund, raised and distributed funds for local hospitals and patients.¹²⁸ With a more overtly political focus, the suffrage movement from the 1890s onwards allied with Welsh nationalist and

120 Cf Michael (n 8 above) 3.

121 M Longley, 'Prudent progress in the Welsh NHS' (Nuffield Trust, 29 July 2015).

122 See, for example, Blackwood Miners' Institute, 'Our history'.

123 A J Cronin, *Adventures in Two Worlds* (Gollancz 1952) 140.

124 'NHS 70: Aneurin Bevan day celebrations in Tredegar' (*BBC News*, 1 July 2018).

125 P O'Leary (ed), *Irish Migrants in Modern Wales* (Liverpool University Press 2004) 44, 190, 207.

126 D Leeworthy, *A Little Gay History of Wales* (University of Wales Press 2019) 115ff.

127 *Ibid* xi.

128 K Bohata et al, *Disability in Industrial Britain: A Cultural and Literary History of Impairment in the Coal Industry, 1880–1948* (Manchester University Press 2020) 108.

socialist campaigns to promote social goals, including health.¹²⁹ Much more recently, Muslim women of South Asian heritage established and ran food delivery and support services in Cardiff and Swansea for communities disproportionately affected by the COVID-19 pandemic.¹³⁰ Mutual aid in these diverse forms has not been exclusive to Wales, of course.¹³¹ We make no plea for exceptional virtue here. Rather, we do point to the framing of many of these initiatives in terms of specifically national traditions and note that this provides a discursive resource for argument about the development of health law in Wales.

Sustainability

Welsh historical experience also informs a concern with sustainability on the part of government and civil society. From the early nineteenth century, Wales was a major site of extraction (eg coal and slate mining) and primary processing (eg steel production) for the British economy. With ownership largely resting outside the country, this skewed development and created a massive burden of ill-health and environmental damage. Deindustrialisation since the 1960s, again imposed by external political and economic forces, has seen many of these difficulties persist and added new challenges (eg addiction and mental illness).¹³² Over the same extended period, the Welsh language lost in prestige and numerical predominance, being marginalised by processes of British state-formation (eg in law and education) which privileged English.¹³³ Not surprisingly perhaps, devolved Wales has taken conservation and regeneration as key goals. An official commitment to achieve a bilingual society was matched by GOWA 1998, which imposed a duty on the Assembly (now Senedd) to promote sustainable development across all policies.¹³⁴

The latter commitment has been given fuller legal form in the WBFGA 2015, which seeks to put the UN's Sustainable Development Goals at

129 U Masson, "Hand in hand with the women, forward we will go": Welsh nationalism and feminism in the 1890s' (2003) 12 *Women's History Review* 357.

130 R Youle, 'The untold story of the Swansea Bangladeshi community and how it is reacting to the coronavirus pandemic' (*Wales Online*, 30 July 2020); E Ogbonna et al, 'First Minister's BAME COVID-19 Advisory Group report of the Socioeconomic Subgroup' (Welsh Government, 2020) 8.

131 See, for example, M Gorsky, 'Mutual aid and civil society: friendly societies in nineteenth-century Bristol' (1998) 25 *Urban History* 302.

132 C Jones, 'In what sense sustainable? Wales in future nature' in Evans et al (n 119 above) 91–104.

133 See G A Williams, *When Was Wales? A History of the Welsh* (Penguin 1984) 245–248.

134 See, respectively, Welsh Assembly Government, *Iaith Pawb: A National Action Plan for a Bilingual Wales* (WAG 2003); GOWA 1998, s 121.

the heart of public administration, as we have noted above. The Act's underpinning ethos of ensuring 'that the needs of the present are met without compromising the ability of future generations to meet their own needs'¹³⁵ can be read as a response to the instrumental depletion of Welsh lives and landscapes in the past. Its legal operationalisation of moral duties to coming generations is unique in the world.¹³⁶ A statutory duty is placed on public bodies to work collectively to achieve seven wellbeing goals, which include health and wellbeing, equality, and global responsibility. Citizens may seek judicial review of official decisions that fail to take account of these goals,¹³⁷ but it is the office of the Future Generations Commissioner which is central to overseeing the Act's implementation. Though the Commissioner cannot formally compel or prevent specific actions, she can issue recommendations to public bodies, including the Welsh Government, regarding their impact on sustainability.¹³⁸

Widely acknowledged as a landmark initiative, the detail of the Act is not without its critics. In particular, as Haydn Davies has argued, it only imposes on authorities a relative duty 'to endeavour to achieve' its goals, not a duty to secure well-defined results.¹³⁹ As such it runs the risk of functioning merely as a means of signalling Welsh virtue, fine talk to compensate for Cardiff's still limited legislative capacity.¹⁴⁰ Against this, however, must be set recent developments, notably the success of the current Commissioner in objecting to the construction of the M4 relief road through environmentally significant wetlands near Newport in 2019.¹⁴¹ More broadly, the Act has reinforced the more holistic approach to health, which includes, but also goes beyond clinical care and traditional public health, consistent with the promotion of equivalent 'One Health' approaches in Wales.¹⁴²

Equality

The value of equality is implicit in the foregoing discussion of solidarity and sustainability. In both cases we observed historic and

135 WBFGA 2015, s 5.

136 See, further, R Jones, 'Governing the future and the search for spatial justice: Wales' Well-being of Future Generations Act' (2019) 197 *Fennia* 8.

137 WBFGA 2015, ss 3–5. See H Davies, 'The Well-being of Future Generations (Wales) Act 2015: duties or aspirations?' (2016) 18 *Environmental Law Review* 41.

138 WBFGA 2015, s 20.

139 Cf Davies (n 137 above) 47.

140 Evans et al, 'Introduction' (n 119 above) 9.

141 The Planning Inspectorate, 'M4 corridor around Newport (M4CAN) inspector's report on public local inquiries' (Welsh Government, 21 September 2018).

142 See, for example, Learned Society of Wales, 'One health Wales: the importance of People's Wellbeing and Planetary Health *Western Mail Column*' (21 June 2017).

contemporary trends extending the category of ‘who counts’, beyond the wealthy and beyond the present generation, respectively. Of course, the definition of equality, and of the duties that attend it, are contested among philosophers and practitioners. Against the thin conception of ‘equality of opportunity’ can be set the maximalist ‘equality of outcome’.¹⁴³ Both differ from the now well-articulated understanding of ‘equity’ which directs that policymakers and legislators be guided by the different health needs of different groups in allocating resources.¹⁴⁴ Considerations of health equity are applicable both within Wales and across the UK. Thus, persistent disparities in life-expectancy and ill-health divide even neighbouring regions such as Cardiff and the former mining valleys. This is a challenge for the fair distribution of resources for health promotion as between regions internally. Equally, Wales as a whole has the highest percentage of the population over 70 and the highest rate of smoking in the UK, as well as the worst incidence of asthma in Europe.¹⁴⁵ In its turn, this casts a harsh light on the current funding settlement between Wales and the UK Treasury, based on the so-called Barnett formula, which is not calculated with reference to this greater health need.¹⁴⁶

Further guidance, and a firmer normative basis for the value of equality, is provided by the international and domestic human rights materials which were considered above as sources of current Welsh health law. Thus, the principle of non-discrimination is enshrined in the ICESCR.¹⁴⁷ As the Committee responsible for that treaty made clear in its General Comment on the right to health, this is a non-derogable obligation of states (including the UK and through it the Welsh Government) – that is, it binds the authorities even in emergency situations, such as pandemics.¹⁴⁸ The principle is common to most human rights instruments, including the UN CRC, which, as we saw, is (in part) directly enforceable in Welsh law.¹⁴⁹ The Equality Act 2010 imposes a more detailed and enforceable equality duty on public bodies, including health boards and NHS trusts, to avoid and eliminate

143 K Saito, ‘Social preferences under risk: equality of opportunity versus equality of outcome’ (2013) 103(7) *American Economic Review* 3084–3101.

144 S Nesom, ‘5 things you should know about gender equality in Wales’ (Wales Centre for Public Policy, 5 December 2018).

145 See Hayward (n 5 above) 75.

146 Wales Governance Centre, ‘Barnett squeezed? Options for funding floor after tax devolution’ (Wales Governance Centre, December 2016).

147 Committee on Economic, Social and Cultural Rights, General Comment No 3: The Nature of States Parties’ Obligations (art 2, para 1 of the Covenant) (1990).

148 See further, S Sekalala and J Harrington, ‘Communicable diseases, health security and human rights’ in L Gostin and B Mason Meier, *Foundations of Global Health and Human Rights* (Oxford University Press 2020).

149 See preamble to Convention on the Rights of the Child 1989.

unlawful discrimination and safeguard the rights of people with a protected characteristic, for example race, gender, disability, sexual orientation.¹⁵⁰ Significantly, given the correlation between social deprivation and ill-health in Wales, discrimination based on economic status was not included among the protected grounds, however.¹⁵¹

Cardiff administrations have made high-profile commitments to equality, collaborating with the World Health Organization on assessment tools for measuring progress towards health equity for example.¹⁵² Nonetheless, as in the case of sustainability, there is a risk that commitments remain ‘short on detail, light on action’, ‘aspirational’ rather than substantive, as has been argued of the high-profile *Advancing Gender Equality in Wales Plan* of 2020.¹⁵³ A more focused and critical approach was taken by Professor Emmanuel Ogbonna and colleagues, commissioned by the Welsh Government’s BAME COVID-19 Advisory Group to report on the disparate impact of the pandemic in 2020.¹⁵⁴ The Ogbonna report identified structurally determined inequality in health provision and outcomes, as well as the disproportionate participation of minority staff in ‘frontline’ occupations, as key causes of this skewed outcome. Explicitly drawing on the MacPherson report into the murder of Stephen Lawrence,¹⁵⁵ it indicated that a lack of ethnic minority representation among NHS leaders and health decision-makers and a failure to engage with all service users and communities in Wales amounted to ‘institutional racism’.¹⁵⁶ The report and the Welsh Government *Action Plan* based on it constitute a further important source of Welsh health values, foregrounding, as they do, active anti-racism over passive multiculturalism and attending carefully to the intersectional nature of discrimination in health, particularly as regards women of colour.¹⁵⁷

150 Equality Act 2010, s 149.

151 See B Hepple, *Equality: The Legal Framework* (Hart 2014) ch 1.

152 M Honeyman et al, *Digital Technology and Health Inequalities: A Scoping Review* (King’s Fund and Public Health Wales 2020); ‘[New agreement between WHO/Europe and Welsh Government launched to accelerate action on health equity](#)’ (WHO, 5 November 2011).

153 Welsh Government, ‘[Advancing gender equality in Wales plan](#)’ (March 2020); M S Jones, ‘Neo-liberal feminism in Wales’ in Evans et al (n 119 above) 27–42, 32; A Parken, ‘Putting equality at the heart of decision-making, Gender Equality Review (GER) Phase One: International Policy and Practice’ (Wales Centre for Public Policy, July 2018) 9.

154 Ogbonna et al (n 130 above).

155 Sir W Macpherson of Cluny, *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny* (The Stationery Office 1999).

156 Ibid [1]–[5], 6.1.

157 Welsh Government, *An Anti-racist Wales: The Race Equality Action Plan for Wales* (2021).

The three values picked out here – solidarity, sustainability and equality – do not exhaust the field of course. The familiar canon of autonomy, beneficence, non-maleficence and justice will no doubt feature too in coming discussions of ethical practice and law-making in a devolved Wales.¹⁵⁸ Indeed, we can be confident that they already do, as a result of shared British institutions (eg the General Medical Council) and curricula (eg in law schools and medical schools). Nor have we specified these three values in anything like the detail required for philosophical argument or legal reasoning. That will be an important task. But, as we have suggested, it is one which is beyond the scope of this article. Rather, we have used the discussion to suggest Welsh distinctiveness, on the one hand, and the variety of sources, past, present, legal, cultural, which might inform a more systematic study of values, on the other. In this respect we draw support from the work of Alasdair MacIntyre on metaethics.¹⁵⁹ For him, the labour of identifying, arguing about and changing values is one of engagement with tradition. Careful study of context, attending to the particularities of time and place, is essential to identifying or reconstructing an ethic. Like MacIntyre, we see tradition as anything but fixed, essentialist or uncritical. Nonetheless, like him we argue that the elaboration of values must start from somewhere at some time. As such, we diverge from those more universalist views on the source of values, associated with liberal bioethics, which dominated the writing of British medical law from the 1980s onwards.¹⁶⁰

CONCLUSION

‘For Wales, see England.’¹⁶¹ The notorious entry in the *Encyclopaedia Britannica* has echoed through the legal disciplines until recently. In our case, an unacknowledged Anglo-British frame set the terms of scholarship in health law. The commonplaces that sustained the field, ideas of medical progress and tragic scarcity of resources, the gentleman practitioner, the sovereign patient and so on, drew on

158 See T Beauchamp and J Childress, *Principles of Biomedical Ethics* (Oxford University Press 2009).

159 A MacIntyre, *Whose Justice? Which Rationality?* (Duckworth 1988) 349ff. For an insightful introduction, see D Solomon, ‘MacIntyre and contemporary moral philosophy’ in M C Murphy, *Alasdair MacIntyre* (Cambridge University Press 2003) 152–175.

160 J Montgomery, ‘Law and the demoralisation of medicine’ (2006) 26(2) *Legal Studies* 185–210.

161 *Encyclopaedia Britannica*, 9th edn (1889).

a wider elite culture, specific to the UK in the post-war decades.¹⁶² As we have suggested, those commonplaces can no longer be taken for granted. Their rhetorical potency is waning, the frame broken by constitutional, institutional and cultural developments. Devolution has seen the creation of four health systems in the UK, each subject to the direction of different political masters and administrative cadres, who are themselves accountable to four different polities. Diverse political and professional traditions in health have been revived, as shown by the emphasis on public health and non-market forms of care delivery in Wales. In place of a single UK health law, then, we can observe the emergence of separate corpora of Welsh, Scottish, Northern Irish and English legislation. Each is necessarily subject to interpretation and application in a distinct body of case law, regardless of jurisdiction. Of course, all four retain a considerable family resemblance, due not least to the continuing UK-wide application of key statutes, but also to the shared past of a common NHS and even longer-standing public health practices. Indeed, as COVID-19 has demonstrated, common health threats, porous borders and population mobility mean that significant overlaps in policy and law will continue to be essential to effective health promotion. Nonetheless, convergence and coordination will be achieved increasingly from four separate starting points, rather than being imposed from the centre.

The challenge for health law scholars at this juncture, we would argue, is threefold. First, in embracing this newly apparent plurality, they need to pursue careful analysis, synthesis and criticism of each body of statutes and relevant case law in its own terms and in comparative perspective with reference to developments across the UK, but also internationally. This will be essential as an aid to interpretation, a spur to law reform and a guide to citizens, professionals and policymakers seeking clarity as to rights, duties, powers and liabilities. Second, scholars will need to attend to jurisdictional disputes and overlaps, to tangled hierarchies and heterogeneous sources of norms which may impede both health promotion and the rule of law. The presence of 'jagged edges' arising from uneven or incomplete allocation of powers is likely to be an enduring phenomenon. Moreover, grasping these struggles exceeds the capacity of purely doctrinal methods. Socio-legal and law and humanities approaches will be indispensable in grasping the implications of normative pluralism and contested territoriality for British health governance. Third, renewed attention to values, their content and their relation to legal developments, will be required in order to give coherence to extant materials, as well as enabling evaluation and reform. We have suggested that such values are best

162 See further, Harrington (n 117 above) ch 1.

identified through engagement with inherited practices and traditions, as well as contemporary legal and policy materials. This is always an active, critical and contingent process, one encapsulated for our context in the words of historian Gwyn A Williams: 'Wales is an artefact which the Welsh produce. If they want to. It requires an act of choice.'¹⁶³

163 Williams (n 133 above) 304.