

## THE NATIONAL HEALTH SERVICE IN SCOTLAND

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This briefing provides an overview of the National Health Service in Scotland, and covers the following:

- a history of recent policy reforms
- structural organisation of the NHS in Scotland
- public health & levels of health care provision
- governance and accountability
- standards of care - regulation, inspection, complaints and enforcement
- financing of the NHS in Scotland
- policy divergence in the UK

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## KEY POINTS

- Health is predominantly devolved under the terms of the Scotland Act 1998, with only a few areas reserved to Westminster (e.g. abortion, licensing of medicines and regulation of health professions). The key legislation underpinning the NHS in Scotland is the National Health Service (Scotland) Act 1978 ([p4](#))
- Since devolution the NHS in Scotland has undergone major changes such as the dismantling of the Conservative government's internal market, with the abolition of NHS Trusts and a greater focus on partnership rather than competition ([pp4-6](#)).
- The NHS in Scotland is predominantly run by the 14 area NHS Boards which are responsible for the planning and provision of health services for their local populations. The Boards are accountable to Ministers and thus to Parliament. There are also a number of 'Special Health Boards' which provide services on a national basis e.g. Scottish Ambulance Service ([p7](#)).
- The functions of the NHS can broadly be divided into the improvement of public health and the provision of health services at varying levels. These levels are generally described as primary, secondary and tertiary care. Primary care relates to services such as GP practices and most health care is provided at this level. Primary care is considered a 'gateway' to receiving more specialist care. Secondary care is generally provided in a hospital based setting and includes both elective and emergency care. Tertiary care refers mainly to the provision of services for people with an existing illness who require greater levels of specialist expertise (e.g. Cancer services) ([pp10-11](#)).
- Performance of the NHS is monitored via the 'HEAT' performance management information system. The acronym HEAT relates to 4 key objectives; Health Improvement, Efficiency and Governance Improvements, Access to Services and Treatment Appropriate to Individuals. Boards draw up Local Delivery Plans of how they will achieve the objectives and performance is monitored by the Scottish Executive and reviewed annually in the Boards' accountability review with Ministers ([pp11-12](#)).
- Standards in the NHS are not the responsibility of one regulatory body. NHS Quality Improvement Scotland produces standards for care, against which they inspect Board performance. Inspection reports feed in to Board accountability reviews with Ministers who have the power to direct Boards and also to intervene in the case of service failures. Patient complaints are dealt with by NHS Boards in the first instance but can be directed to the Scottish Public Services Ombudsman if necessary ([p12](#)).
- The majority of the health budget is allocated to the 14 area NHS Boards via the Arbutnott Formula. This formula aims to distribute money in a way that reflects varying need between Boards. It is therefore based on measures such as population, morbidity, mortality and deprivation. In 2007-08, the planned Health and Community Care budget is £10.25bn. This now equates to just under 33% of the Scottish Executive's total budget ([pp13-14](#)).
- Health policy in the UK countries has diverged since the start of devolution. This is most notable in England where the Department of Health has continued to pursue market based reforms. Wales has pursued policies designed to give greater local control, whereas reform in Northern Ireland stalled following the suspension of the Assembly in 2002 ([p14](#)).

## INTRODUCTION

The National Health Service (NHS) was established in Britain in 1948. Despite a growth in private health provision and insurance, the NHS provides the vast majority of health care in Scotland.

“The purpose of the NHS is to secure through the resources available the greatest possible improvement in the physical and mental health of the nation by: promoting health, preventing ill-health, diagnosing and treating injury and disease and caring for those with long-term illness and disability who require the services of the NHS.” (Department of Health, 1996)

Health policy was, in the main, devolved to the Scottish Parliament under the terms of the Scotland Act 1998 (the ‘1998 Act’). However there are some areas of health policy which remain reserved namely:

- abortion
- xenotransplantation (the use of non-human organs for transplantation)
- embryology, surrogacy and genetics
- licensing of medicines, medical supplies and poisons (although decisions on whether the NHS should fund licensed medicines are devolved)
- welfare foods
- the regulation of health professions (although regulation of professions not regulated prior to the 1998 Act is devolved)
- health and safety

The NHS in Scotland carries on the principle of collective responsibility by the state for the provision of comprehensive health services free at the point of use for all. Services are funded from central taxation and access should be based on need. The main legislation providing the legal framework for the NHS in Scotland is the National Health Service (Scotland) Act 1978 (c.29).

## HISTORY OF SCOTTISH NHS REFORMS SINCE 1997

The following outlines the key policy developments in the Scottish health service since 1997.

### 1997-1999 – DISMANTLING THE INTERNAL MARKET

In 1997, the incoming Labour government inherited a national health service which in the preceding years had undergone radical changes at the hands of the Conservative government. These changes were geared towards introducing elements of market economics to the NHS in a bid to curtail spending and improve efficiency. Such elements included the creation of NHS Trusts and a purchaser/provider split, whereby fundholding GPs ‘purchased’ care on behalf of their patients from providers such as Acute Hospital Trusts. This system received much criticism from opposition parties and the Labour manifesto pledged to abolish the internal market.

Carrying on the manifesto commitment in Scotland, the 1998 white paper ‘Designed to Care’ (Scottish Office, 1997) signalled the end of the internal market, GP fundholding and contracting for services. Trusts lost much of their autonomy, becoming responsible in an administrative sense for the provision of services while policy making rested with the area Health Boards. The purchaser/provider split became the strategic/service divide and Primary Care Trusts were

introduced to manage General Practice and Community Services. GPs were given the go-ahead to come together voluntarily to form Local Health Care Co-operatives.

Health Boards retained the strategic role of improving and protecting the health of their local population and were now considered as strategic public health organisations. The competition of the internal market was to be replaced with a culture of partnership.

### **1999- 2001 – A NEW APPROACH TO PUBLIC HEALTH**

The new Labour government in Scotland and the UK also introduced a new approach to public health and in February 1999, the Scottish Office published 'Towards a Healthier Scotland' (Scottish Office, 1999). This white paper was notable in that it acknowledged health inequalities and the wider determinants of health, something of a departure from previous political focus solely on individual responsibilities and lifestyles. The focus for health improvement was set out across three areas:

- Life Circumstances (e.g. Employment, Housing and Education)
- Lifestyles (e.g. Smoking, Diet and Physical Activity)
- Health Topics (e.g. Cancer, Coronary Heart Disease Stroke and Mental Health)

The shift in emphasis from lifestyles to life circumstances was also highlighted by a review of the national funding formula (discussed in more detail on pg 11). The formula (known as the Arbuthnott formula) proposed that any distribution of funding to NHS Boards should take greater account of need within the population, including morbidity, mortality and deprivation. The formula was first used in 2001/02.

### **2001-2003 – REFORMING GOVERNANCE AND ACCOUNTABILITY**

In 2001, the Scottish Health Plan (Scottish Executive, 2001a) continued the dismantling of the internal market with changes to governance and accountability in the NHS. Health Boards became 'unified' with NHS Trusts, although this was primarily a change to the membership and role of Health Boards, as opposed to a unification of the actual structures.

The unification was intended to provide a single focus of accountability for the performance of the local NHS system and NHS Boards were required to produce a single local health plan for the area. The health plan also announced the introduction of the Performance Assessment Framework (PAF) which was to be used by the Executive to monitor performance and health improvement within each NHS Board area.

### **2003-2005 – SINGLE SYSTEM WORKING AND COMMUNITY HEALTH PARTNERSHIPS**

The 2003 white paper 'Partnership for Care' (Scottish Executive, 2003a) took previous reforms even further by announcing the abolition of NHS Trusts entirely. The paper also proposed the establishment of Community Health Partnerships as a means of making health services more accountable to local communities and better able to represent local interests within NHS Boards.

The organisational changes outlined in the white paper were implemented via the National Health Service Reform (Scotland) Act 2004 (asp 7) (see [Spice Briefing SB\\_03-92](#)) (Robson, 2003) and were seen as the final stage in dismantling the NHS internal market. The functions of the NHS Trusts were incorporated into Operating Divisions of NHS Boards and became responsible for overseeing primary and secondary care but, unlike Trusts, have no independent

legal status. This leaves a single tier of governance and accountability in the shape of the 14 NHS Boards.

The role and influence of Local Health Care Co-operatives (and thus, primary care) was also strengthened by evolving into Community Health Partnerships (CHPs). Although still in their infancy, it is envisaged that the CHPs will make the link between primary and acute care more seamless, with resources and responsibility for decision making being devolved to them. In addition they have been charged with involving patients and a broader range of healthcare professionals in the decision-making process.

In 2004, the Executive also published 'Fair to All, Personal to Each' (Scottish Executive, 2004) which set out new targets for waiting times and announced greater use of independent sector diagnostic and treatment services to bring down waiting times.

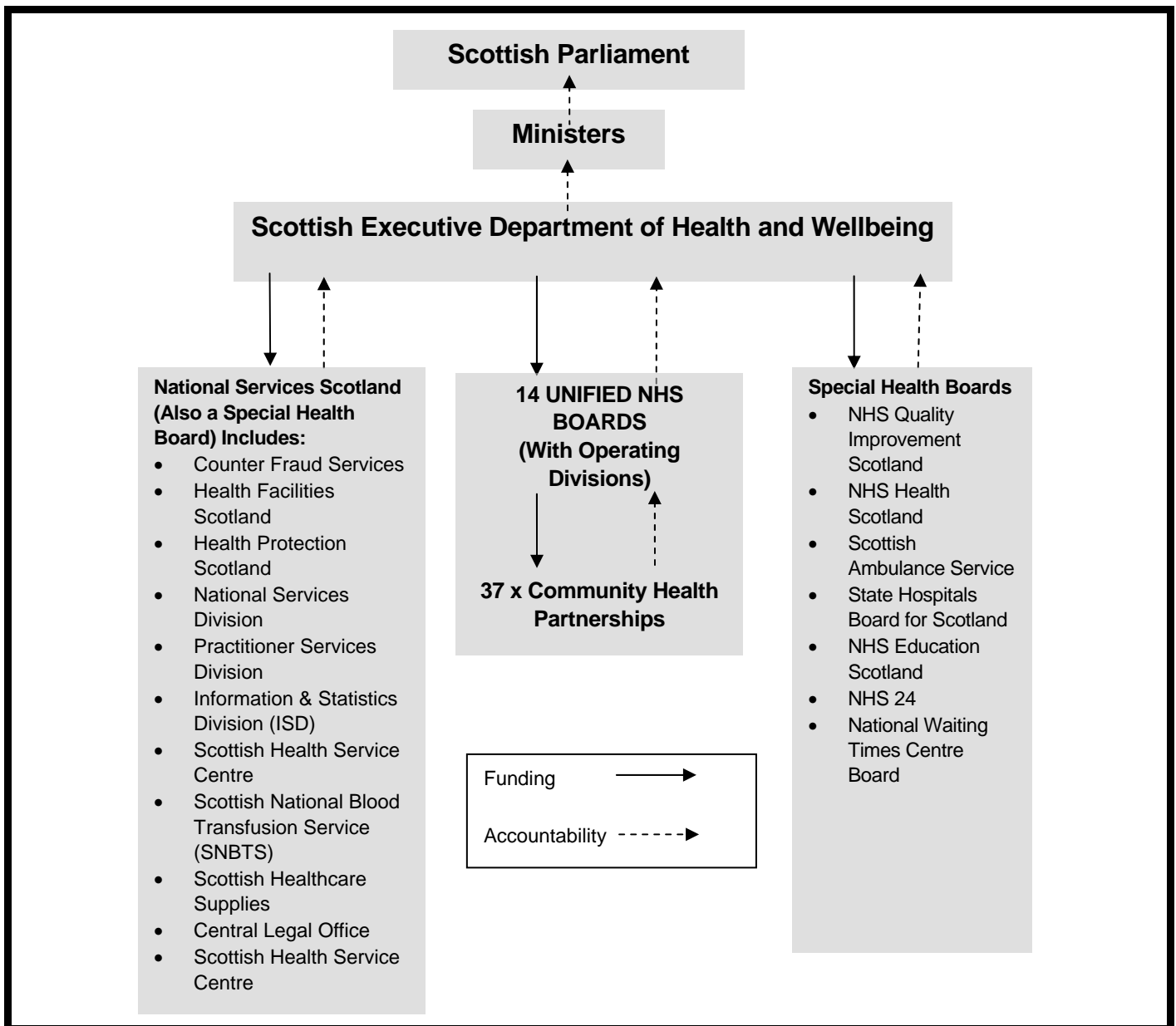
## **2005-2007 – THE KERR REPORT AND DELIVERING FOR HEALTH**

At the same time that there was increasing public concern over service reconfigurations and the centralisation of services, then Health Minister, Malcolm Chisholm, convened an expert group tasked with looking at how NHS services could be developed in the longer term. In May 2005, the National Advisory Group on Service Change (2005) published its final report (also known as the '[Kerr Report](#)'). The group set out its vision of the NHS as:

“Our vision for the NHS is that it should deliver safe, high quality services that are as local as possible and as specialised as necessary”

One of the key themes to emerge from the Kerr report was the concept of shifting the balance of care closer to the community and away from acute services. This would partly be provided by 'anticipatory care' where care is geared towards preventing unscheduled admissions to acute care, but also by preventing future ill-health and improvements in the management of long-term chronic conditions. The Executive issued its response to the Kerr report in the publication of '[Delivering for Health](#)' which generally endorsed the Kerr report. For a more in-depth summary of the Kerr report, see [SPICe briefing SB05-62](#) (Robson & Payne, 2005).

## CURRENT ORGANISATION OF THE NHS IN SCOTLAND



### **Parliament**

In Scotland, Cabinet Secretaries and Ministers are responsible and accountable to Parliament for the overall running of the NHS in Scotland. The [Health and Sport Committee](#) is the main committee dealing with the health aspects within the portfolio of the Cabinet Secretary for Health and Wellbeing and his/her deputies.

### **Scottish Executive Department of Health and Wellbeing**

In Scotland, the [Scottish Executive Department of Health and Wellbeing](#) has responsibility for health policy, the administration of the NHS, community care and some responsibility for social work. The department is headed by the Director General for Health who is the Chief Executive Officer of the NHS.

The department is subdivided into Directorates alongside which, there is the Chief Medical Officer (CMO) who is the principal medical adviser to the Cabinet Secretaries and is also closely involved with the Chief Scientist Office (CSO). The CSO oversees the management and funding of research within the NHS in Scotland.

### **NHS Boards**

The National Health Service (Scotland) Act 1972 (c.58) allowed for the establishment of area health boards to assess health needs and administer the provision of relevant health care. There are 14 [NHS Boards in Scotland](#)<sup>1</sup>. The functions of the Boards can broadly be divided into:

- Strategy Development – the boards are responsible for the development of a single local health plan
- Resource Allocation in accordance with strategic objectives laid out in the health plan
- Implementation of the health plan
- Performance Management of the local NHS system

Each member of the Board has equal voting rights and membership is made up of:

**Non-Executive Lay Members** – These members are appointed by Ministers after open competition and include the NHS Board Chair and lay members appointed from the likes of community groups and local business.

**Non-Executive Stakeholder Members** – These members are appointed and paid in the same way as lay members but are representatives of specific interests that must be represented on the Board. They include Local Authority members, the Chair of the Area Partnership Forum, the Chair of the Area Clinical Forum and a University Medical School member (where appropriate).

**Executive Members** – Executive members hold a place by virtue of their employed position within the Board. They include the NHS Board Chief Executive, Director of Nursing, Director of Public Health, the Director of Finance and the Medical Director.

Each NHS Board now contains 'Operating Divisions'. These divisions subsumed the responsibilities of the former NHS Trusts.

### **Community Health Partnerships**

Community Health Partnerships (CHPs) were created following the enactment of the National Health Service Reform (Scotland) Act 2004 (asp 7). CHPs are the successors of Local Health Care Cooperatives (LHCCs) and have been charged with the management of community health services. Acting as committees or sub-committees of the Board they are also supposed to:

- Bring together those providing community based health and social care services
- Feed local needs into Board planning and resource allocation
- Provide a focus for integrating primary care and acute services
- Get involved in community planning to tackle poverty and deprivation in their area
- Be the main NHS agent for the implementation of the Joint Future agenda (aimed at developing closer joint working between the NHS and Local Authorities)
- Be the main NHS agent for implementing the strategy for integrated children's services

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<sup>1</sup> There were 15 NHS Boards until 31 March 2006 when Argyll & Clyde NHS Board was dissolved and management of its services split between Greater Glasgow and Highland NHS Boards.

The exact responsibilities and make-up of each CHP differ and are outlined in their '[scheme of establishment](#)'. At present there are 37 CHPs in operation in Scotland. Each CHP should have a Public Partnership Forum made up of patient groups, voluntary organisations and members of the public. The forums are supposed to give local communities a chance to influence local services.

Funding for CHPs is devolved from the NHS Boards and varies in its extent between CHPs.

### **Special Health Boards**

These are boards that provide health services to the whole of Scotland, not just a local population. The special health boards in Scotland include:

	<b>Functions</b>
<b>NHS Health Scotland</b>	<a href="#">NHS Health Scotland</a> is the agency responsible for improving population health. NHS Health is responsible for all aspects of health improvement including understanding the determinants of health, gathering evidence on how to improve poor health, disseminating evidence and evaluating such activities aimed at improving health.
<b>NHS Quality Improvement Scotland (NHS QIS)</b>	<a href="#">NHS QIS</a> is tasked with taking forward the quality agenda in the NHS. Its functions include providing advice and guidance on effective clinical practice, setting standards for care and reviewing and monitoring performance
<b>NHS Education Scotland (NES)</b>	<a href="#">NES</a> is responsible for designing, commissioning and quality assuring education, training and lifelong learning for the NHSScotland workforce
<b>Scottish Ambulance Service (SAS)</b>	<a href="#">SAS</a> Provides ambulance services for accidents, emergencies and non-emergencies
<b>State Hospitals Board for Scotland</b>	<a href="#">The State Hospital</a> provides high security forensic and psychiatric care at Carstairs in Lanarkshire
<b>NHS 24</b>	<a href="#">NHS 24</a> is responsible for the provision of out-of-hours services in partnership with NHS Boards
<b>National Waiting Times Centre Board</b>	<a href="#">The Waiting Times Centre Board</a> is responsible for the Golden Jubilee National Hospital which is used as a means of bringing down waiting times in certain specialties
<b>NHS National Services Scotland (NSS)</b>	<a href="#">NSS</a> provides a range of services that are required nationally such as Scottish Healthcare Supplies, the Scottish Blood Transfusion Service and Health Protection Scotland

# PUBLIC HEALTH & LEVELS OF HEALTH CARE PROVISION

## PUBLIC HEALTH

Public health is the “the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society” (Committee of the Inquiry into the Future Development of the Public Health Function, 1988). This generally occurs through assessment of need and the implementation of appropriate measures to meet that need. Such measures include, but go beyond, the provision of health services, with involvement in activities such as health promotion and disease prevention. The national lead for improving public health lies with the Chief Medical Officer and NHS Health Scotland. Locally, however, each NHS Board also contains a Public Health Department and a Director of Public Health who holds a place on the Board. Directors of Public Health publish an annual report which is independent of the Board and is supposed to highlight what they perceive to be the issues of most concern regarding the health of the local population.

## LEVELS OF HEALTH CARE PROVISION

The provision of health care services can be divided into:

- Primary Care – Family and Community Health Services
- Secondary Care – Hospital departments and Outpatients
- Tertiary Care – Clinical Specialities that require highly specialised skills or support services

In 2005, the NHS in Scotland employed 129,424 whole time equivalent staff ([Information and Statistics Division](#), 2007a).

### **Primary Care Services**

‘Primary care’ refers to the services provided by health professionals, either in clinics and practices, or at home. The category includes GPs, nurses, health visitors, dentists, optometrists, pharmacists and other specialists. Primary care is normally the first point of contact with the NHS and primary care professionals are considered the gatekeepers to secondary and tertiary services. Approximately 90% of patient contact is handled at this level.

Within primary care there are four general practitioner services: medical, dental, pharmaceutical and optical. All general practitioners are usually independent of the NHS and are contracted by local NHS Boards to provide their particular service. Their contracts are generally negotiated on a national basis (e.g. the new General Medical Services contract for GPs) but NHS Boards still have some scope to negotiate local contracts or to employ practitioners directly as salaried NHS employees.

It is normal for GPs to work together as partners in a local practice and also within a larger practice team which includes practice nurses, district nurses and health visitors. Every UK citizen has the right to be registered with one of these practices and the services offered at these points are free of charge, although prescriptions are free only to certain groups<sup>2</sup> with non-exempt people having to pay a charge of £6.85<sup>3</sup>.

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<sup>2</sup> Exemption categories are detailed in NHS [Health Department Letter 2005\\_10](#)

<sup>3</sup> Correct at time of writing. Prescription charges are usually increased annually via subordinate legislation. The most recent uplift was contained in the National Health Service (Charges for Drugs and Appliances)(Scotland) Amendment Regulations 2007

There are approximately 16 million GP consultations per year in Scotland and on average most people will consult their GP over 3 times a year (Information and Statistics Division, 2007b). Some services provided by other professions are chargeable (eg dentists and opticians) although eye and dental check-ups were made free in 2006.

### **Secondary Care**

'Secondary Care' is mainly hospital-based health care provision. Services range from emergency care (via Accident & Emergency) to non-emergency treatment (usually through outpatient departments and referrals from GPs). In recent years there has been a move towards providing more care and treatment in outpatient departments as well as preventing unscheduled admissions. The following provides a summary of recent acute care activity (Information and Statistics Division, 2007c):

- In 2005/06 there were almost 4 million attendances at Outpatients and Accident & Emergency, 1.2 million of which were accounted for by new patients
- In 2005/06 there were almost 600,000 planned admissions to hospital
- In 2005/06 there were 480,665 emergency admissions, a rise from 304,049 in 1984/85
- In 2005/06, 1,055,217 operations were performed in the NHS. 65% of these were treated as day cases

A large amount of care is also provided by nurses and allied health professionals in an acute care setting but data are not currently available to demonstrate the extent of this.

### **Tertiary Care**

Tertiary care refers mainly to the provision of specialist services for people with an existing disease which requires higher levels of expertise and support services. An example of this would be oncology services such as those provided at the Beatson Oncology Centre in Glasgow. Tertiary care services are usually provided in a limited number of locations around the country and some are provided via a 'Managed Clinical Network'.

Managed Clinical Networks (MCNs) are groups of health professionals (eg doctors, nurses and specialists) and healthcare organisations (eg local health services, social service departments and support groups) working together to provide treatment and care to patients. The members of the MCN are permitted to co-ordinate their work with health professionals and organisations beyond their own NHS Board area.

### **Community Care**

This relates to care provided by the NHS in partnership with local authorities to help vulnerable people, such as the elderly or people with disabilities, to live in their own homes rather than in institutions. For a more in-depth look at community care, please see [SPICe briefing 07/29](#) (Payne, 2007).

## **GOVERNANCE AND ACCOUNTABILITY OF NHS BOARDS**

A commitment to improved performance and accountability in the NHS was set out in the document *Rebuilding Our National Health Service* (Scottish Executive, 2001) with the first

attempt at this being in the shape of the 'Performance Assessment Framework' (PAF). The PAF was supposed to encourage improvement in the performance of the NHS by focussing on key measures of health priorities, and therefore also ensure the NHS was accountable for its performance both locally and nationally. The PAF contained national targets and priorities and NHS Boards reported to the Executive on their performance against all of these key indicators at least once a year within the Annual Accountability Review. However, the PAF has recently been replaced with a new performance management information system. The new system is called 'HEAT' with the acronym relating to four key objectives:

- **Health Improvement for the people of Scotland** – improving life expectancy and healthy life expectancy
- **Efficiency and Governance Improvements** – continually improve the efficiency and effectiveness of the NHS
- **Access to Services** – recognising patients' need for quicker and easier use of NHS services
- **Treatment Appropriate to Individuals** – ensure patients receive high quality services that meet their needs

Each objective has a number of targets and measures associated with it and targets are reviewed on an annual basis through consultation with Boards. Each NHS Board now produces a Local Delivery Plan (LDP) which contains something called a 'planned performance trajectory' showing how they will achieve the targets. The Scottish Executive agrees the LDPs with Boards and these then form an annual 'performance contract'.

## **STANDARDS OF CARE - REGULATION, INSPECTION, COMPLAINTS & ENFORCEMENT**

Standards in the NHS are not overseen by one regulatory body in the same way that care services are (i.e. by the Care Commission) and the roles of regulation, inspection, complaints and enforcement are divided between different organisations.

NHS Quality Improvement Scotland has some of the roles in that it sets standards for care and treatment and will inspect Boards' performance against them. However, NHS Boards still have a large degree of autonomy and NHS QIS does not have the power to enforce sanctions against Boards not meeting the standards. Performance against standards ultimately feeds into NHS Boards' annual accountability reviews with Ministers, who have the power to direct Boards and also to intervene in the case of service failures. It is worth noting, however, that independent hospitals, independent specialist clinics and dental services come under the authority of the Care Commission.

In relation to [complaints](#) about NHS services, these are dealt with in the first instance at an NHS Board level. All complaints should be handled within 20 days of receipt and if not resolved to the complainant's satisfaction they can then ask for their case to be reviewed by the Scottish Public Services Ombudsman. Prior to the National Health Service Reform (Scotland) Act 2004 (asp 7), Local Health Councils were in place to assist individuals in bringing complaints against Boards. This avenue was lost once the health councils were abolished but by April 2006 NHS Boards were supposed to have entered into a partnership with the Citizen's Advice Bureau to provide independent advice and support for the public. The [Scottish Health Council](#) (part of NHS QIS) also aims to ensure the views and opinions of the public are properly taken into account by NHS Boards.

## FUNDING OF THE NHS IN SCOTLAND

Levels of funding are determined by Cabinet Secretaries and Ministers and approved by the Scottish Parliament. Historically, health funding was distributed to the NHS Boards via a weighted capitation formula known as SHARE (Scottish Health Authorities Revenue Equalisation). This formula took into account four measures when considering the distribution of resources:

1. A measure of the population served by each health board
2. A measure of the composition of each board's population in terms of age and sex
3. A measure of the relative health needs over and above the size, age and sex of the population existing within each Board (mainly due to differences in the morbidity of Board populations)
4. A measure of any unavoidable excess costs of delivering healthcare in sparsely populated areas

Following *Designed to Care* in 1998 (Scottish Office, 1998) a review of the allocation of resources for health was initiated. Sir John Arbutnott chaired the review which aimed to develop a formula for distributing resources between Boards that reflected the varying levels of need and would therefore promote equitable access to health care.

The review group reported back in July 1999 (Scottish Executive, 1999) and presented a formula that essentially retained the four principles of the SHARE formula but also included the budgets for GP prescribing and primary care services (previously excluded from SHARE) and extended the measure of health needs to include over 50 indicators of morbidity and deprivation. The formula is commonly known as the 'Arbutnott formula' and was rolled out over five years. It is currently in the process of being reviewed by the [National Resource Allocation Committee](#).

The planned Health and Community Care<sup>4</sup> budget for 2007-08 is £10.25bn. Over the period 2002-08, the health budget has increased by 39.3% and now equates to 32.8% of the Scottish Executive's total spend. Most of this money will come from general taxation and National Insurance contributions and will be allocated by the Scottish Executive Health and Wellbeing Department (in accordance with the Arbutnott formula). Approximately 70% of the health budget is allocated directly to NHS Boards, with the remainder including (among other things) funding for Special Health Boards, research, capital, education and training (Scottish Executive, 2006).

## POLICY DIVERGENCE IN THE UK

Although the Labour party has been the dominant political party in the UK since 1997, some distinct divergence in health policy in the four UK countries has emerged since devolution.

### ***England***

Despite the initial pledge to abolish the internal market in the NHS, Whitehall has pursued market reforms which could be considered very similar to the Conservative party reforms of the 1990s. The emphasis of reforms has primarily been on market based incentives such as choice and competition, with the money 'following the patient'. Under 'Practice Based Commissioning'

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<sup>4</sup> This is money within the Scottish Executive Health Department and does not include Local Authority Grant Aided Expenditure on Community Care

GP practices are given an indicative budget which they use to purchase care on behalf of their patients, and with 'Choose and Book' patients now have a choice as to which hospital they receive elective inpatient care from. However, hospitals cannot compete on price as treatment costs are based on a nationally determined tariff.

The best performing hospitals can also apply to become Foundation Trusts in order to gain greater autonomy. These not-for-profit Trusts are able to opt out of government targets and decide their own financial and clinical priorities. They are also accountable to local communities as opposed to Ministers and have the freedom to sell off capital and borrow money.

England has also made greater use of the private sector than any of the other UK countries by purchasing capacity from the independent sector for the treatment of NHS patients.

### **Wales**

Welsh reforms have tended to focus on the greater integration of services at a local level as well as a greater emphasis on public health. In 2003, the 5 Regional Health Authorities were abolished and replaced with 22 Local Health Boards. The local Board boundaries were made coterminous with local government areas and they were given responsibility for the commissioning of services. In addition, the Welsh health plan of 2001 was notable in that it focused on 'health' as opposed to 'health services', thus prioritising public health. This was continued in the 2005 policy document 'Designed for Life' which set out a 'twin-track approach' whereby the causes of poor health are tackled at the same time as improving the services that deal with ill-health. Although not market based, these reforms have some similarities with the English reforms in that the commissioning of services is the responsibility of local bodies. On the other hand, the focus on partnership is similar to the Scottish approach.

### **Northern Ireland**

The NHS in Northern Ireland already differed from the rest of the UK prior to devolution in that the management of health and social services are merged. To date, much of the organisational structure of the Conservative party's reforms still remains in the Northern Ireland NHS with changes only recently being announced. The lack of reform in NI can be contributed to the suspension of the Assembly in 2002. Nevertheless, recent announcements have pointed to the development of a more streamlined structure based around one Health and Social Services Authority (previously 4) and four Health and Social Services Boards (previously 19).

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