MEDICAL PRACTICE

Contemporary Themes

Devolution

The BMJ held a one-day conference in Glasgow on 3 April. The participants, from England, Scotland, and Wales, discussed whether they would like the Health Service in each country to devolve and the probable effects of the Government's White Paper on devolution—Our Changing Democracy: Devolution to Scotland and Wales. By invitation three of the participants prepared working papers which were circulated beforehand. These are printed below, together with an edited version of the discussion. The sessions were chaired by the editor of the BMJ, Dr Stephen Lock, and an assistant editor, Dr Gordon Macpherson.

Working papers**A case for devolution of health care**

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The new Scottish dimension to British politics makes devolution¹ almost certain, and indeed there is a likelihood now of a strong legislative assembly with economic power. The changes in Wales, though similar, would be less radical. The medical profession in Scotland, given the chance, would probably vote against devolution, but as medicine is being taken along by the strong devolutionary tide, a Canute-like stance against it is not appropriate. Thus rather than detain ourselves over the merits of devolution, it would be more important for the health care workers in Scotland to make contingency plans for the coming of the assembly.

Nevertheless, it is worth going over the case for devolution briefly, and many of us prefer to be cheerful about its effects.

The usual arguments for devolution are not entirely applicable to Scottish medicine (unlike, say, the Scottish economy or land ownership) since we have a degree of devolution already. We have our own health care administration at the Scottish Home and Health Department in Edinburgh and we have our own colleges of physicians and surgeons, in which we take a touchy pride. The survival of our traditions and the persistence of a good health service in Scotland is partly due to devolution to these fine institutions. None of the critics of devolution, I think, would wish to do away with these bodies.

Thus when we talk of devolution in health care it is of the

devolution of political control of medicine to the Scottish Parliament, and the discussion, on both sides, must inevitably draw from personal convictions about the optimal size of governmental units in the UK.

The arguments for political devolution in medicine are in miniature those for devolution in general. A Scottish assembly would encourage the separate character of Scottish medicine, it would study and respond to the particular needs of health care in Scotland, and would give better government of Scottish medicine (the "small would be beautiful" argument²). Enoch Powell's view, when Minister of Health, is relevant: "Policies which are formed centrally are bound to be slower to change and less adaptable to alterations of circumstances and demand, than if responsibility were diffused and decisions independent. The great machine is bound to have a one-track mind, to be cumbrous and unresponsive, to abhor variations, and to be insensitive to the world around it."

Taking these advantages of devolution in turn, the separate character of Scottish medicine is well known and admired. It arises from the fraternal and democratic nature of Scotland's society and its love and respect for learning. General practice is seen at its best in rural Scotland, and in, say, Lossiemouth or Sanquhar you will find the kind of primary health care that the rest of the world wants and has not got. There is also a dimension of internationalism about Scottish medicine which produced men like John Boyd Orr, who, from Aberdeen, designed and eventually directed the World Food and Agriculture Organisation. Moreover, the Scottish health care workers are unusual in being solidly behind the concept of the NHS.

Secondly, devolution will make easier the study of Scotland's particular health problems (of which there is no lack of statistics, as shown below) and the orientation of health care towards our own needs.

Lastly, devolution will give good government by being nearer the problems and hence quicker and more sensitive to particular needs. Thus with our assembly we would not have the present delay in legislation on the health problems of the oil industry off Scottish shores,³ a delay familiar to those who have waited six years for reform of (or even parliamentary debate on) the Scottish Divorce Laws.

Possibilities

A nation with particular problems and a traditional talent for medical care adds up to the need for and the likelihood of success in devolution. The proposals in the White Paper on Devolution based on the Kilbrandon Report make scant reference to devolution in medicine, other than to allow changes of all kinds, subject to the approval of the Secretary of State. These "governor-general" powers have been widely criticised and may be withdrawn from the final Bill. On the big issues, the health care workers in Scotland must surely support an assembly with strong economic powers, as the poor health of our country is so dependent on our relative poverty and massive social deprivation. Scotland, which once had a top position in the European health league, now lies 15th in the European mortality statistics, while England and Wales lie eighth.⁴ Infant mortality rates in Scotland are higher than in England and at unacceptable levels in Glasgow, once a healthy city. In Scotland there is a three-fold difference in the infant mortality rates between social classes I and V, which has been unchanged since 1948, and the health of Scotland's social class I equates only with England and Wales's class III.⁵ Smoking and the abuse of alcohol are seen at their worst in Scotland, and we lead Europe in lung cancer and coronary heart disease deaths: Scotland is the most toothless nation in the advanced world.⁶

Leaving the question of the needs, the White Paper makes provision for making the Minister of Health a non-political figure, and the profession would be wise to seize on this or alternatively support the idea of a health commission, a partnership between the profession and the Government, which would at last involve doctors in the tough central decision-making in health care. The all-party special committees of the assembly suggested by the White Paper were surely intended as a protection for the health service from arbitrary actions of a Minister of Health and as a way of airing facts and policies. For instance, the abandonment of the district general hospital building plan and the substitution of the cheap "nucleus" hospital was announced outside Parliament, and there seems no way that the reasoning behind it or the wisdom of it can be debated.

As for bread and butter issues, we would be best to have Scottish consultant and junior contracts. The remarkable difference in the health care system north and south of the border is shown in the extracts from details of the type of consultant contract^{7 8} (see table).

Percentage of part-time consultant contracts

Specialty	Scotland	England/Wales
All ..	16.1	54.7
General medicine ..	21.1	67.2
General surgery ..	38.4	78.1
Thoracic surgery ..	0	57.5
Pathology ..	0.8	43.0

The consultant unrest in England is understandable, as also is the lack of support from Scotland for industrial action. Also, consultants in Scotland—alone in the UK—voted in favour of the consultative document's proposals for the abolition of pay-beds.⁹ Moreover, the juniors' present contract is threatening our traditional training of academics and pathologists for the rest of the UK. There is widespread distaste in Scotland for the overtime payments system, and if adequate salaries can be substituted our traditions may be preserved. We therefore

need our own negotiations with the assembly: indeed we have weakened our English colleagues' negotiations with our perverse voting. As the White Paper states, "the unity of the United Kingdom does not mean uniform treatment for all its parts."

Fringe benefits of devolution will be a reduction in the excessive and debilitating commuting to London required of our leaders and representatives. Perhaps our scientific societies and conferences may pull themselves north more often, and it is to be hoped that a separate royal commission will report on the health service in Scotland to our assembly—a separate Scottish royal commission on the legal profession has been set up. Lastly, the extent and the causes for our massive loss of Scottish trained doctors will be an urgent matter for the assembly. Safety standards for drugs are best left on a UK basis and a separate GMC for Scotland is probably unnecessary now, after the doctors' revolt of two years ago and the Merrison Report.

A devolved Scottish health service will have to steady itself for two major crises—one of manpower and one of resources. In manpower we may do well, since our strong university medical faculties can cope with the anticipated shortfall in manpower arising from continued emigration and a reduction in intake from abroad. In the determination of priorities in the spending of the NHS budget effectively, I hope that Scotland may do well in coming to terms with the fearful choices in expenditure which will come to all countries sooner or later. This can only be done if a country's health care workers support the philosophy of the health care system they work in. Scotland will be better placed to meet this challenge than the UK as a whole.

Problems

There are, of course, worries associated with devolution; great changes must carry risks. Financially, Scotland gets 11.2% of the NHS cake for 9.7% of the population (but only 8.6% of national research funds). Thus there is uncertainty that this present NHS expenditure on Scottish health will continue, though it has been required since 1948 for our rural population, our four large medical schools (which produce 17% of all UK doctors), and our greater health care needs. The Cabinet might risk a cut in this figure, but devolution may be a way of protecting it, putting the authority of the assembly behind the Secretary of State's yearly request. The future spending of the assembly on health (as distinct from schools or houses) must remain problematical and we must await the appearance of the health policies of all the political parties. There are those who fear health care spending in Scotland might fall: it might, in fact, rise. My prediction for 1978 is that it will stay at present levels. Secondly, there is concern about possible increases in bureaucracy after devolution, but as we already have administrative devolution to the Scottish Home and Health Department, extra health care expenditure will not be involved. Indeed, the politicians planning for the assembly are agreed that economy and simplification are needed and one tier of the new local government and health administration should be removed. The Prime Minister stated frankly in the devolution debate that to have allowed reorganisation of local government (and health care) to proceed while devolution was being planned "was an unthoughtout and clearly scatty proposal." But, a reasonable delay before any further surgery to our administration is done would be humane and desirable. Lastly, there is concern about the main change after devolution—Scottish political control. There is concern in some quarters that we cannot match the political wisdom and maturity of the politicians at Westminster. The Minister of Health must surely be flattered by this sudden attachment, but I fear it is simply:

"Always keep a hold of nurse
For fear of finding something worse."

This is bad advice to a child and worse for a nation: responsibility will bring forth the men (and women) and keep in Scotland the talent that we normally send out to run other countries.

Conclusion

A crucial debate in the Commons later this year will decide if devolution is to become law. If it comes, devolution of health care will merely give Scotland the legislative power already held in the federal states of Texas, Ukraine, and Alberta (which runs its own health care system within Canada with substantial Scottish professional help). Size alone is not important, as many of the federal states of West Germany are smaller than Scotland. I think Scotland is prepared for this freedom to run its own health system. If a partnership can be fused between the profession and the Government, and there are signs that it can be done, in Scotland we can build a health service which will work as the NHS was intended to do. The NHS pioneered a socially just and economical system of providing health care, and we may soon have an obligation to show how the money-eating clinical and administrative monster of health care throughout the world can be controlled.

Perhaps at a time when the goals and priorities of health care are under scrutiny throughout the world and as each advanced country in the world moves bit by bit towards systems like the NHS, Scotland with its remarkable traditions in medical care may be given this chance to run its own health service, and in particular to be free of the millstone of the profession's industrial action over problems irrelevant to Scotland. Most health care planners would dearly like to have Scotland's opportunities and I hope that we can rise to the challenge. The future success or failure of a Scottish health service can only partly be judged from the facts and figures available at present: thereafter the debate revolves round faith in devolution or contentment with centralism.

References

- ¹ *Our Changing Democracy: Devolution to Scotland and Wales*, Cmnd 6348. London, HMSO, 1975.
- ² *Lancet*, 1975, **2**, 1136.
- ³ *British Medical Journal*, 1976, **1**, 354.
- ⁴ *Which?*, August 1975.
- ⁵ *Lancet*, 1975, **2**, 667.
- ⁶ *Health Services in Scotland: Report for 1974*. Edinburgh, HMSO, 1975.
- ⁷ *Hansard*, House of Commons, 12 February 1976, col 377.
- ⁸ *Hansard*, House of Lords, 17 December 1975, col 1556.
- ⁹ *British Medical Journal*, 1976, **1**, 457.

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Financing the Scottish Health Service

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This conference is concerned firstly with discussing how the Scottish Health Service gets the money it needs and distributes it among the various parts of the Service, and how these arrangements are likely to be affected by devolution.

Present mechanism

Traditionally the mechanism for financing the Health Service has been through the annual submission, for approval by Parliament, of the supply estimates. The estimates for the Scottish Health Service are put forward by the Scottish Home and Health Department, independently of but in parallel with the estimates for England and Wales.

Since the 1960s, following the report of the Plowden Committee on the Control of Public Expenditure,¹ the inadequacy of this piecemeal, year-by-year approach to the planning of public expenditure has been recognised. So machinery has been developed for surveying and controlling the field of public expenditure as a whole (including expenditure by local authorities and nationalised industries as well as by Government departments) in relation to prospective resources over a period of years ahead. This is what is known as the PES system—Public Expenditure Survey Committee, a committee of senior officials which oversees the whole operation.

The first stage in the PES machinery is for each department to submit to the Treasury an annual return showing the estimated cost of maintaining existing policies for the coming five years. These estimates are discussed by the Treasury with the various departments, and a comprehensive report is submitted for consideration by Ministers, who then take decisions on the aggregate programme of public expenditure and its allocation to the various departmental programmes. In reaching their decisions they will have regard to the resources likely to be available and to changing views on priorities, and will weigh the claims of particular departmental programmes against one another. Estimates based on these decisions are published in a White Paper which is discussed by Parliament and can be examined in detail by the Parliamentary Select Committee on Expenditure. The White Paper figures then provide the basis for each department's supply estimates for the forthcoming financial year. The most recent White Paper on public expenditure covered the period to 1979-80.²

Given the complexity of this machinery, the outside observer may be forgiven if he cannot see the wood for the trees. It is easy enough to talk of weighing priorities against one another and taking decisions about the realignment of public expenditure to give effect to these priorities; but in a going concern like the Health Service—to say nothing of all the other services which are competing for the country's resources—the scope for reorientation is bound to be limited. A certain established level of service must be maintained, and must be reasonably uniform between one part of the United Kingdom and another. Some parts of the Service, like the family practitioner services, are largely beyond departmental control, expenditure being determined mainly by the decisions of individual practitioners. The great bulk of hospital expenditure is determined by the need to maintain existing establishments and pay existing staff; and the opening of a new establishment automatically pre-emptes a corresponding share of revenue expenditure. In any given year most of the money is already in effect committed: the resources available for development are relatively marginal, and in times of economic stringency they are liable to be cut even further.

Scottish flavour

How far, within this system, has Scotland been able to fashion the Health Service in a distinctively Scottish way? The standard of services provided to the public must be reasonably uniform throughout the United Kingdom; accordingly, there must always be close contacts between the different health departments in planning the development of their separate services. The PES process will also tend to draw attention to differences between parallel departmental programmes. Nevertheless, since the NHS started the Scottish Department has been able to build up a pattern of services which differs in many respects from the English pattern and reflects a distinctively Scottish approach.

In terms of total expenditure Scotland has done reasonably well: the 1975-6 estimates for the Health Services show an expenditure of £97 per head of population in Scotland, compared with £79 per head in England and £82 in Wales. But comparisons of this kind tend to be odious, and it may be better to consider differences in the distribution of resources within the different countries. Close comparisons are made difficult for the outsider by the differences between Scotland and England in the detailed