

FROM COMPETITION TO COLLABORATION IN THE DELIVERY OF HEALTH CARE: IMPLEMENTING CHANGE IN SCOTLAND

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INTRODUCTION

The National Health Service has yet again found itself in a period of organisational and cultural change. Having endured some six years operating within the context of a competitive market, the new Labour Government was resolved to remove the market from the NHS and replace it with a system which was based upon cooperation and collaboration. The new system, they have argued, should be based upon partnership and driven by performance. The new system is to some degree built upon structures that have been carried over from the past. There is still a divide between the planning and the delivery of services. The key difference, of course, is that this divide does not represent the buyer and seller approach of old.

The main objective of this analysis is to provide an account of the embryonic developments that have taken place within the NHS in Scotland with respect to the changes that became operational in April 1999. The changing role of the principal organisations is identified as is the means by which they are expected to interact. The analysis is largely empirical in its approach, based as it is upon a programme of elite interviews which were carried out during the early part of 1999. It is still at this stage of the proceedings rather early to make definitive judgements about the likely success of this most recent re-organisation, but is illuminating, if nothing else, to be in a position to identify emergent issues and to offer some speculation as to the way they are likely to develop in years to come.

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THE CONTEXTUAL SETTING

Since 1974, the NHS has been exposed to a succession of major reorganisations in each of the component parts of the United Kingdom. In addition to these organisational upheavals, however, the last two decades have witnessed a constant procession of developments aimed at encouraging within the NHS a stronger managerial culture (Klein 1995). Indeed, the market based changes that were introduced into the NHS in 1991 had sought to strengthen the managerial initiatives of the 1980s. Part of the reasoning for introducing a market based approach into the NHS was rooted in the belief that marketisation would create a climate of financial incentives. Such a climate, it was reasoned, would be more conducive to managerial change and development (Butler 1992).

Following the election of the Labour Party to power in 1997, it soon became clear that competition was to be replaced by a new regime based upon cooperation and collaboration. Labour's critique of the market was that it encouraged short-termism and mistrust, and represented a gross misuse of resources. Not, however, wishing to return to the command and control arrangements that had been in place prior to the market, Labour has sought to embark upon a third way driven by what they call 'integrated care' based upon partnership and driven by performance (Cm 3807 1997, p.5).

At a rhetorical level, Labour has quite clearly underlined its commitment to the NHS. Their stated objective is to rebuild the NHS so that the service is once more the envy of the world. The NHS has of course always been prominent in the hearts and minds of the Labour Party faithful and in recognition of this the Prime Minister took the opportunity to hail its creation as the greatest act of modernisation ever achieved by a Labour Government (Cm 3807 1997, pp.3-4). But the process of modernisation does not seek to dwell upon the achievements of the past and of 'old Labour'. It is to the future that 'new Labour' has focused its attentions and its aim of bringing efficiency and quality together alongside a belief in the importance of fairness and partnership. Yet we might be prone to ask at this stage whether Labour has a clear vision of the future and a strong sense in which the key ingredients of this third way are clearly spelled out. Is the so called 'third way' an innovative strategy in the making or is it quite simply a political fudge that is neither fish nor fowl?

Hostile as Labour may have been towards the market based approach, there are elements of this that they have elected to preserve. For example, operational responsibility for the delivery of acute hospital services still rests

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with free-standing NHS Trusts, albeit vastly reduced in number. We also see continued emphasis being placed upon the need to integrate the medical profession into management arrangements which continue to evolve both in the hospital and primary care settings. Added to this, there is the increased emphasis that is to be placed upon quality and a desire to improve standards up and down the country - to create a truly national service. The trick, it seems, is to retain what works while casting aside the unproductive elements of the market-based approach. The third way, we are told, 'will neither be the model from the late 1970s nor the model from the early 1990s. It will be a new model for the 21st century' (Cm 3807 1997, p.11).

In addition to changes in the area of health care specifically, the creation of devolved parliaments in Scotland and Wales has given increased emphasis to the territorial dimension of British government (McConnell 2000). The market was ushered into the NHS in 1991 on the back of legislation which was applied equally to England, Scotland and Wales. These more recent changes, while predating the establishment of devolved parliaments, have a much more pronounced territorial flavour. Indeed, one might expect that, through time, each of the devolved parliaments might wish to make their own mark upon the organisation and delivery of health care. For the time being, however, while differences of detail are clearly discernible in the organisational arrangements that are evident in each component part of the UK, a common thread is to be found in terms of efforts to promote a philosophy of cooperation and collaboration. Are we to believe, therefore, that we are witnessing the territorial fragmentation of government within the UK while at the same time seeking to achieve greater integration within each of the territories?

As far as Scotland is concerned, there have always been differences in arrangements governing the organisation and delivery of health care when compared to England and Wales (Hunter 1982, Hunter and Williamson 1991, Hunter and Wistow 1987). Even after the introduction of the market into the NHS both north and south of the border, organisational differences remained clearly visible. Scotland for example lacked the separate arrangements for the management of family practitioner services which operated in both England and Wales (Ham 1994). Culturally, however, Scotland has also tended to be quite distinct. Traditionally a safe haven for the Labour Party, many of the trappings of the marketised NHS were viewed with suspicion if not outright hostility by both the public and, often less overtly, by those involved in the delivery of health care. General Practitioners had generally been more reluctant to embrace fundholding status than their counterparts elsewhere. Added to this, there was a marked reluctance on the part of many Health

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Boards to promote competition between hospitals (Forbes 1999). One senior official had taken the opportunity to indicate during an interview that the market existed largely in name only. Purchasers were more prone to encourage stability, continuity and collaboration. Contracts were often used as accessories after the fact and were indeed seen as a negative force in developing longer term relationships between purchasers and providers (Forbes 1999).

What this all amounts to is that the Government's decision to disengage the NHS from its flirtation with the market was greeted with a considerable amount of support north of the border. The language of the market could now give way to the realities of improving health status and health care. Where under market conditions divisions had been created with a view to promoting competition, the new regime would seek to promote joint working, a sharing of ideas and an attempt to make more cost-effective use of resources. Moreover, where the marketised NHS had concentrated upon improving the efficiency and effectiveness of services, the new regime is conscious of the need to go beyond the service orientation and improve the health status of the population. But of course there is a challenge here which takes us beyond the realms of organisational change and seeks instead to emphasise the importance of cultural change. The NHS is not only being asked to take an introspective look at ways and means of enhancing its own contribution to the nation's health, but is also being asked to secure the cooperation of a whole variety of other agents in the field who are in a position to contribute to the nation's health.

METHODS AND APPROACHES

The principal means of soliciting evidence for this research project was to conduct a series of semi-structured interviews over a period of six months - December 1998 to May 1999. During the first few months the new organisations were working in a shadow capacity and in April and May were just beginning to settle in. Inevitably, therefore, while respondents were being encouraged to relate to their experiences, a fairly generous measure of speculation could also be detected. This speculative approach was due largely to the embryonic nature of the new arrangements. Nevertheless, it was decided to examine a cross section of organisations within the central belt of Scotland, which might in some way provide an insight into the key themes and issues which would emerge and develop. The sample was based upon three Health Boards and, from each of these geographical areas, a Primary Care Trust and an Acute Hospital Trust. Interviews were conducted with the

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chairperson of each organisation, Chief Executives, and, in the Health Boards, the Directors of Public Health. Out of the 21 possible interviews, 15 were conducted within the time frame available; only two individuals refused to be interviewed, citing a lack of time as the explanation.

Much of what follows in terms of empirical evidence has been drawn from the interview programme. None of this has been attributed to any one individual or organisation, to protect assurances that were given at the outset regarding confidentiality and anonymity. It is recognised that the interviews were conducted at an early stage in the process of reform but it is also recognised that they will form the basis of ongoing research so that it is useful at this early stage to establish markers which might inform future research. The analysis that follows examines the key themes that emerged during the interview programme. To begin with the nature and organisation of the new arrangements is outlined together with new developments in the planning process. Not least, some attention is devoted to the innovative changes that have taken place in primary care. Finally, the analysis moves on to consider the interplay between key organisational types and the nature of the challenge that the new agenda of co-operation and collaboration has offered up.

SERVICE PLANNING AND HOSPITAL PROVISION

General responsibility for service planning and health improvement in Scotland remains with 15 Health Boards. Membership of these Boards has been left largely undisturbed with the exception that Trust Chairs now act *ex officio* as non executive members of their Health Board. Continuity is also observable in terms of the geography of the Boards, though it remains to be seen how long a Scottish Parliament might wish to leave this undisturbed. A number of senior officers and members had indicated during the course of interviews that they fully expected the Scottish Parliament to reduce quite substantially the number of Health Boards, perhaps even going as far as returning to something close to the geography of the five Regional Hospital Boards that operated between 1948 and 1974 (Levitt 1976).

The suspicion that the number of Health Boards might be reduced was in part derived from their enhanced strategic significance under the arrangements that are outlined in **Designed to Care**. The market had all too frequently left Health Boards strategically weak, often preoccupied with fire-fighting tasks and of holding a potentially volatile system together (Shields 1996). Health Boards are now expected to play a more significant strategic role in the

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planning process, and in future this role might be strengthened by increasing their size and reducing their number. For the time being, the central element of each Health Board's strategy is the development of a Health Improvement Plan. Such a Plan represents an attempt to bring Health Boards together with those involved in delivering acute hospital services, and primary and community care with the addition of a constellation of organisations both public and voluntary who have some input to the health of the nation. It is recognised that financial considerations remain an important aspect of these negotiations, but it is hoped that the financial dimension be seen within the context of a system that places greater emphasis upon partnership and performance.

The number of Trusts have been reduced substantially since the demise of the market. The number of Acute Hospital Trusts has been reduced to one per Health Board with the exception of Greater Glasgow and Lothian where geography and the configuration of acute hospital services has not made this possible. Greater Glasgow now has three Acute Hospital Trusts while Lothian operates with two. This represented an attempt to promote a greater degree of coherence in the relationship between Health Boards and Acute Hospital Trusts. Acute Hospital Trusts are expected to take a lead from the Health Improvement Programme and develop objectives to be pursued by way of a Trust Implementation Plan.

In addition, however, to firming up the relationship between Health Boards and Acute Hospital Trusts, there is the question of engendering a greater degree of coherence within each of the Acute Hospital Trusts. Prior to the operationalisation of **Designed to Care** in April 1999, Hospital Trusts were quite separate entities. There were 47 acute, community, and combined trusts operating in mainland Scotland. There are now 15 Acute Hospital Trusts operating alongside an entirely new form of Trust - Primary Care Trusts - which now also exercise the responsibilities previously carried out by the former community trusts (see later). This move towards larger Acute Hospital Trusts was designed to reduce the problem of fragmentation, which was endemic to the market-based approach. Prior to 1999, fragmentation had created difficulties in the coordination and development of services. It was reasoned, therefore, that bringing previously separate acute hospital services together under one organisational umbrella might encourage a more coherent approach to service provision. This is a particularly important issue since one of the major challenges that lie ahead for the NHS in years to come is the rationalisation of hospital services and, to some extent, a re-evaluation of the need for hospital-based care.

PRIMARY CARE AND HEALTH IMPROVEMENT

One of the more innovative aspects of **Designed to Care** was the creation of Primary Care Trusts. Each of the mainland Health Boards has one Primary Care Trust with the exception of Argyll and Clyde where it was thought that the geography of this area was best served by the creation of two Primary Care Trusts. The role of the Primary Care Trust is essentially to provide support for GPs, to assist GPs in the development of policies for primary care, and to work in partnership with Health Boards and Acute Hospital Trusts to develop and implement the Health Improvement Programme. The Primary Care Trust is also charged with responsibility for improving the quality and standards of clinical care (Cm 3811). Within each of the Primary Care Trusts, GPs have been invited to form Local Health Care Cooperatives, and, in spite of the fact that these arrangements remain voluntary, the vast majority of GPs have signed up. The Cooperatives are intended to cover natural communities, though these communities vary in size from populations of 25,000 at the lower end to 150,000 at the higher end. Each Cooperative is to become 'an operational unit within the Primary Care Trust responsible for managing and delivering integrated services across a defined area. The Cooperatives will be separate management entities but an integral part of the Primary Care Trust' (Cm 3811, p.36).

There are clear differences in what has been introduced in Scotland in comparison to England. In England, GPs may provide support and advisory inputs at a minimum level through a four-stage continuum to becoming free-standing bodies responsible for commissioning care, and accountable to the Health Authority. GPs in Scotland will not be commissioning care but will nevertheless be expected to provide a much more innovative, efficient and effective input into the delivery of health care. The sub-text of these most recent reforms that have been introduced into the NHS is that general practice needs to modernise and develop. This was an argument in support of GP fundholding but the principle of fundholding was rejected by the new Government.

In Scotland it was probably less problematic to eradicate fundholding than south of the border. One chair-designate of a Primary Care Trust had suggested that in Scotland it was easier to talk about cooperation in health care than of competition and entrepreneurship. Nevertheless, it is likely to become increasingly apparent that some of the objectives which lay behind GP fundholding remain active ingredients of the new arrangements. For one thing, with a Government agenda that recognises the importance of containing public expenditure, there is clearly a view that primary care needs

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to be cash limited and, like GP fundholders before them, Local Health Care Cooperatives are faced with cash limited budgets.

More specifically, however, on the theme of cooperation and integration, there are key objectives germane to Primary Care Trusts and Local Health Care Cooperatives which were arguably much more difficult if not impossible to achieve within the context of GP fundholding. GP fundholding hardly represented a coherent response to the health care needs of a specific geographical area. Their client base was altogether much more disparate. On this basis, the allocation of financial resources to primary care had proved to be problematic (Bruce and Jonsson 1996). The budgets of GP fundholders were largely historically-based, not needs-based or population-based. The 1999 reforms, on the other hand, should in time allow primary care to utilise a base-weighted population approach as Primary Care Trusts serve an identifiable geographical area. Moreover, it was not entirely self evident the extent to which GP fundholding had brought general practice closer to the NHS. Fundholding had to some extent allowed GPs to preserve their traditional sense of detachment from the NHS as independent contractors. A clear objective of the new arrangements is to encourage primary care to become a much more integral part of the NHS.

There has been a considerable amount of rhetoric in recent years about the development of a primary-care-led NHS. Introducing a sense of proportion into this debate, one senior officer had suggested that it is not terribly productive to thrust leadership onto any one sector of the NHS. Some sectors, he argued, would lead at different times for different reasons. The bottom line, therefore, may then be the extent to which sectors are willing and able to come together to provide a seamless approach to service provision. In this regard **Designed to Care** has placed considerable emphasis upon collaboration between the acute hospital sector and primary care, believing no doubt that primary care ought to be playing a more active part in redefining the role of the hospital sector. Joint Investment Funds are a key component in building a closer working relationship between primary care and the hospital sector. The Funds are essentially a mechanism by which Acute Hospital Trusts can transfer resources to Primary Care Trusts with a view to locating the delivery of some types of health care within a more appropriate and cost effective setting - namely primary care. It is expected that Primary Care Trusts might be in a position to play a leading role here by taking the initiative in identifying services that might be more appropriately provided within a primary care setting.

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Bringing all of this together is a sense in which there is a belief that primary care must become much more involved in moving health care closer to the population it serves and of providing meaningful support for population-based efforts to improve health status through prevention and health promotion. The question of promoting health and preventing illness and disease has been the subject of a consultative document (Cm 3584) and more recently a White Paper (Cm 4269). Within the context of these documents are the Labour Government's desire to tackle long-standing problems associated with poor health status and inequalities in health. Within this context, the role of primary care is considered to be vital:

Perhaps more than any other area of health care, health promotion is dependent for its success on giving individuals real control over their own choices ... primary care interventions offer an ideal opportunity not only to put the message across, but to discuss it with individuals and help them to decide how to respond. ... [L]ong term success depends upon [the integration of prevention and health promotion] into the day to day working of the primary health care team.
(Cm 3584, p.53)

COLLABORATIVE PLANNING IN ACTION

Evaluating the operation of the new arrangements is at this stage rather premature as it will take several years at least for the new philosophy to take root and produce results. Nevertheless, there is a sense at this stage in the proceedings that it is important to examine the aspirations of key participants with a view to laying down markers for the future. In the analysis that follows two principal areas will be examined in terms of the way that they might develop. First, the means by which the planning function within the acute hospital sector might operate within the context of the newly developed Health Improvement Programmes and Trust Implementation Plans. Secondly, the means by which the newly established Primary Care Trusts are expected to provide a more coherent and effective input into the delivery of care and otherwise to meet the health care needs of the population.

Acute Hospitals

As indicated at an earlier stage, **Designed to Care** has sought to increase the strategic significance of Health Boards in terms of health planning and service provision. Within the context of the market, Health Boards had tended to allow their agendas to be dominated by financial considerations and

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putting out fires. There was a tendency to focus on the short term as opposed to developing more stable long term strategies. This had been exacerbated by a tendency for Trusts to think for themselves. Behaviour of this nature had of course been encouraged under market conditions where there was little real control over what hospitals actually did. In an effort to address this deficit, attention has been focused upon the role of the Health Improvement Programme. The first Health Improvement Programmes appeared in Scotland in 1997 and required Health Boards, Trusts, local authorities and others to work together in an open and collaborative manner.

A Health Improvement Programme sets out an overall strategy for improving health over a five-year period, taking account of the respective roles and responsibilities of the various groups involved. The hope is that the involvement of these groups will result in a breaking down of barriers, an aspiration that featured prominently during interviews with key participants. There was a detectable air of optimism, with a number of senior officers and members already able to point to developments which did not or could not happen under the old regime. One of the difficulties with the old regime stemmed from the Conservatives controlling central government while Labour dominated at a local level. This problem was particularly acute in areas such as community care which depended heavily upon the cooperation of local authorities.

Political differences aside, there were problems associated with the style of management that had dominated the NHS during the 1980s and 1990s. Short termism and the tendency to deal with problems as they appeared often encouraged organisations to take more of an introspective look at what they were doing. To be unkind, one might argue that there was something of a bunker mentality at work here and this did little to create a sense of corporate identity. Consequently Health Boards were often much more focused upon the service dimension than on reaching out in a wider sense.

The other issue that respondents were prone to emphasise was that the principles upon which the Health Improvement Programme was based created a stronger sense of ownership over the planning process. Given that Health Improvement Programmes were put in place a year prior to the changes inspired by **Designed to Care** being operationalised, it is possible to say something beyond the realms of conjecture as to how they have operated so far. Early indications show that participants have so far made positive contributions to the planning process and, quite importantly, as one senior manager stated, 'once it was agreed, everyone owned it'. Everything in a Health Improvement Programme, therefore, will have been agreed on the part

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of each of the groups that 'something needed to be done'. Seeing the issues through, however, will be a major challenge for everyone, but the strategic role of the Health Boards may create problems associated with providing a lead. For example, one respondent had indicated that some chief executives might let certain issues slip, particularly when dealing with a variety of local authorities with opposing politics and disparate objectives. The Health Improvement Programme is clearly important but it depends on how seriously it is treated, particularly in terms of seeing it through to implementation.

As far as the hospital sector is concerned, a key influence on the input into the Health Improvement Programme and on meeting its objectives will be the extent to which Acute Hospital Trusts can operate as coherent corporate entities. In some of the Health Boards - for example, Dumfries and Galloway, Borders and Highland - there has only ever been one major acute hospital. Consequently one would not expect to encounter problems associated with merger. In the newly formed Acute Hospital Trusts, notably in the urban areas of Greater Glasgow, Lothian and Lanarkshire, it may be some time before there is a strong sense of corporate identity. For the new management teams, their task was to get the organisations which formed the new Trust to work together. The hope is that the cultures and traditions of individual hospitals can be maintained, and in this way there would be nothing to prevent a corporate approach being taken to area-wide issues. In any case, the way in which the NHS is having to address the future level and configuration of hospital provision requires much more of an area-wide response.

More realistically a bunker mentality might well prevail for some time before the new Trusts would be operating in an integrated manner, with a number of senior managers mentioning a time scale of three to five years. More positively, however, early indications were that some trusts had already been working together in the months prior to merger and this had the effect of easing the process of change. One strategy employed in one Trust, to get the cooperative message across, was to emphasise that the organisation and configuration of services should be developed in response to patient needs. The engine of change would be how to provide services that are most appropriate to those needs that were identified in the Health Improvement Programme. Leadership and change management skills were seen by the Chief Executives as being vitally important. Most wished to avoid symbolic change - new logos, headed paper, new management titles and so on. In one area the Acute Hospital Trust Chief Executive had inherited two Trusts that had in the past been highly competitive. For this reason he had avoided symbolic change and had addressed directly the issue of service provision. He argued

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that 'there would be a need to change the philosophy and attitudes to service provision and recognise that the two acute hospitals were not on the same move to merge'. This position was reinforced within the context of the Trust Implementation Plan in as much as the strategy for the acute services would need to be based upon the distinctive strengths and capabilities of each hospital.

Primary Care

The creation of Local Health Care Cooperatives is intended to create a stronger population-based focus for primary care. Previously, the emphasis had tended to be driven by decisions that individual practices might make regarding service portfolios. The message for Cooperatives is to some extent that 'big is better' and that, from a planning point of view, we are required to look beyond activities of individual practices to plan and deliver services. The Chief Executive of one Primary Care Trust had argued that 'Local Health Care Cooperatives could be the forerunner of large practices as Cooperatives are trying to get practices to work together without actually taking the legal step of becoming larger practices'. On top of this, unlike fundholding where GPs were quite simply purchasing services independently of other practices and the local health strategy, Cooperatives and Primary Care Trusts will give GPs the opportunity to have a say in the planning process.

So far GPs appear to have responded positively to the creation of Cooperatives and early indications do not seem to suggest that decision making is being dominated by practices that previously had fundholding status. Indeed, in one instance, a senior manager had indicated that it was the non-fundholders who were playing a more active role. They had taken the view that fundholders had had their opportunity under the market and should now allow others to have a say. That said, we are still in the early stages of development and while it may be useful to witness some positive inputs from GPs, Cooperatives will also have to achieve more tangible results. Maybe, as Cooperatives develop, we will have a clearer idea of the possible pitfalls associated with collaborative ventures of this nature. Experience from the multifunds that had been in operation in England during the competitive market indicated that there was room for a degree of instability within the context of joint ventures in general practice (Anderson 1994). Was this a problem with the market, or was it more specifically a problem with encouraging joint working amongst GPs?

In addition to strengthening the coherence of primary care, **Designed to Care** emphasised the desire to develop an integrated healthcare system where GPs

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and primary care teams would work with acute hospital sector in the delivery of services. A key feature of this working relationship is to identify opportunities for deciding what type of services might be more appropriately provided in a hospital setting, and what would be best provided in a primary care setting. A great deal of store is being placed upon the operation of Joint Investment Funds which senior managers have continually emphasised 'are not really funds - they are more mechanisms than they are funds'. What is meant by this is that Joint Investment Funds do not represent additional money which is to be made available to the hospital and primary care sectors. It is a recognition that there are opportunities to use existing resources more effectively by providing some services within a primary care setting.

At the time that this research was conducted, Joint Investment Funds were only just in the process of being established and there were sometimes divergent views on the part of participants about the likely success which might be achieved by the Funds. On the one hand, some senior managers had a generally favourable disposition towards what might be achieved, believing that there were significant opportunities to improve the 'seamless' nature of care for patients. Others, recognising that the NHS has a finite pool of resources, questioned whether the Funds might be the best way of achieving this. In addition, there were doubts as to whether the way in which Funds were to operate was clearly understood, particularly by some GPs. One interviewee was of the opinion that some GPs saw the Fund as new money that 'people [were] trying to get their hands on'. The important point was one of trying to build new relationships and encouraging collaboration, but in some cases the legacy of the past in the shape of GP fundholding may have been hindering this process. Other interviewees argued that the Fund should be about going beyond collaborative arrangements and that a Fund was only one area where inroads could be made into congestion in the acute hospital sector. Another would be bed blocking by elderly patients.

At an operational level, senior officers indicated there may be problems in freeing resources, time, and indeed facilities to allow the Joint Investment Fund approach to work. Some of the Primary Care Trust Chief Executives indicated that there could be as much as a three or four way move from one area to the next. There was also some suggestion that problems may occur due to the nature of the Joint Investment Fund projects chosen. At the time of the research many Joint Investment Fund projects were, in the main, small affairs concentrating on the transfer of minor surgery to primary care such as toenail removals, and clinics for the management of pain and diabetes. We have yet to get to the stage of looking to achieve more ambitious resource transfers. Ownership of these projects was seen as a key factor, with

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flexibility also vitally important. One Primary Care Trust Chief Executive gave the analogy of a patch-work quilt consisting of a number of squares that needed to be knitted together:

There will need to be a change in culture, a reduction in suspicion and clarity in parameters in what we are doing. It may be the case that we need to come up with projects that can fit into the quilt.

One of the principal difficulties in attempting to come up with projects that fit the quilt is a lack of vision of what the quilt will look like. **Designed to Care** was remarkably scant on detail where it came to specifying the operation of Joint Investment Funds. This is not to say that the concept and objectives of Joint Investment Funds were misunderstood by senior officers; rather there was uncertainty as to the best way forward. This was supported by the interview programme in a number of different ways. For one thing what came out fairly clearly during the interviews was that a great deal of attention has to be focused upon the 'big' issues during the first year of operation. Inevitably this meant that the development of Joint Investment Funds remained low key. The priority issue during this first year was, as one Primary Care Trust Chair indicated, to get their 'vision' of the future right. Indeed this was echoed elsewhere in the interview programme by a recognition that managers had to get to know GPs and had to learn about how to deliver better services.

Overwhelmingly, therefore, Primary Care Trusts during their first year of operation were becoming aware that there was a huge change-management agenda to be worked through. In addition, however, to securing the co-operation of GPs within the context of Local Health Care Cooperatives and to entering into a dialogue about the future role of primary care in the NHS, Primary Care Trusts were having to look beyond internal management arrangements to ways and means of working alongside Health Boards and Acute Hospital Trusts. In terms of these inter-organisational relationships, **Designed to Care** had also failed to specify clearly the criteria for developing a leading role in the Joint Investment Fund process. It is one thing to rely on the rhetoric of recent years - of a primary-care-led NHS. The reality, as one senior officer had suggested, is that the lead may have to be taken by different sectors at different times in different areas to deal with different issues. This lack of clarity in the planning process was evident from the responses of some senior officers who indicated that they were awaiting action from other organisations so that some Primary Care Trusts, for example, were waiting on the Health Board taking the lead.

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Perhaps somewhat unsurprisingly, there is a clear recipe for variation in the success or otherwise of Joint Investment Funds across Health Board boundaries. Some geographical areas may, for a variety of reasons, be able to progress the Joint Investment Fund initiative more quickly than others, and yet there is also scope for considerable variation existing within the context of individual Primary Care Trusts. One Chief Executive, for example, had recognised that the development of Local Health Care Cooperatives had been patchy and uneven as had relationships between these organisations and the Primary Care Trust. Ultimately, however, a great deal must depend on the willingness of doctors within the acute sector to 'let go' and to encourage a transfer of resources and responsibilities to primary care. Conversely, will GPs be willing and able to take on considerably more responsibility and additional work associated with the relocation of services to primary care? Moreover, let us not forget that there are significant implications for skill acquisition and continued professional development in the already intense working environment of General Practice. These are issues which really must be worked through before the more detailed considerations pertaining to Joint Investment Funds can be developed.

COOPERATION AND COLLABORATION: RHETORIC AND REALITY

What has been outlined so far may in some respects represent a break from the market that had dominated the NHS for much of the 1990s. As to whether we have entered a new era in the public sector in which we are indeed able to identify a new spirit of co-operation and collaboration is a moot point. There was, within the interview programme, some positive feedback regarding the changes that have been introduced into the NHS in Scotland, and also some feeling of optimism that there were now structures in place that would allow a more coherent approach to be taken to the delivery of health care. The crucial question, however, is whether this is all political puff and whether substantive changes have actually taken place.

One must of course try to avoid the danger of being seen as a cynic, predicting that nothing is likely to change and that the NHS is doomed to stagger from crisis to crisis. In an effort to counter this more pessimistic position, it might be argued that for the first time we see two key features clearly on show. First we have some evidence to suggest the emergence of a more ordered approach to the planning and delivery of services. Second, there is some degree of optimism that was absent under the market approach. Key participants at a local level who had kept their own counsel about the

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failings of the market are now in a position to make a more positive contribution. By the same token, however, some have a realistic view about the limitations of the new system and the extent to which it might offer a panacea. But can we ever get it right?

Nevertheless, perhaps more than anything, we may have on offer a system that allows or even positively encourages innovation and learning. The market-based approach had more to do with strong central control than spontaneity and creativity. Doctors, managers and a variety of other organisations now have the opportunity to contribute where, under the old system, mechanisms were not in place to encourage this. The previous system was dominated by fragmentation and fed a constant diet of knee-jerk responses and quick political fixes. Nevertheless, what government is going to let the NHS go and to allow it to deal with problems and opportunities in its own way and at its own speed? We already have the spectre of nationally led quality audit in the sidelines which is indicative of a centre which may quite quickly become much more assertive. The Labour Party has a considerable amount of political capital tied up in the NHS and for this reason would wish to have some influence over its destiny. It may be wishful thinking, therefore, to portray the new NHS as ushering in a period of relative relaxation. One wonders, therefore, whether the Labour-dominated Scottish Executive is so much different from its Conservative predecessors in that it may believe in localism only when it is in accordance with the wishes of the centre (Bruce and McConnell 1995).

On this basis it will be difficult if not impossible for the centre to take a hands-off approach, and this has implications for the extent to which cooperation and collaboration can drive seamless provision. There are several positive features about a system that seeks to encourage a sense of ownership, so that a variety of participants can go away from planning forums with a sense of commitment and a sense of what needs to be done. But is a sense of collective ownership not one of the best ways of masking individual responsibility? This is not an argument in opposition to cooperation and collaboration; it is merely to offer a few words of warning that there are more opportunities for a political fudge.

There is a sense in which the language of cooperation and collaboration gives an impression that all is rosy in the garden. There are no guarantees that this will be the case and there are several opportunities for conflict. The new arrangements have in some senses reduced the potential for conflict by attempting quite explicitly to remove competition and reduce the number of Trusts. On the other hand, a new breed of Trust has been created and we still

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in effect have a tripartite structure which has to be held together in so many senses by good will. In consequence, much depends, not upon legal obligations and organisational arrangements, but - as many respondents have argued - on the need to get people together with both the vision and the will to make the system work. One respondent alluded to this basic principle by saying that you can tinker with the hardware all you like but it is the software you need to get right.

The 1990s represented one of the most significant decades in the NHS since its creation in 1948. 1991 saw the demise of a centrally planned approach and the rise of the market. 1999, however, saw its demise and in its place an attempt to introduce a 'third way'. Whether or not each of these phases represented fundamental change is a moot point. In Scotland the failure to fully embrace the market and retain some elements of central planning illustrated how difficult it can be to achieve cultural change. In the post-1990 period it is perfectly possible that this third way may be based upon artefacts from the bygone age of central planning in conjunction with elements of the market-based approach which were thought to be successful.

Perhaps in the final analysis, while there is clear evidence in Scotland that the market had not been terribly successful, any differences between the third way and central planning may be unremarkable. There was clear evidence from the interview programme that the language of localism was accompanied by a strong measure of centralism and political control. Yet, on the other hand, where the market also exhibited strong centralist tendencies, there is a greater degree of transparency in the post 1999 period. In consequence, there is the possibility that a collaborative approach is less likely to foster the mistrust that was evident during the era of the market. This degree of openness might well act as a catalyst not just for promoting a greater degree of meaningful joint working between Health Boards, Acute Hospital Trusts and primary care, but also for helping to promote a culture of openness within these organisations. Areas where this might be of benefit are in breaking down the barriers that existed between previously separate hospitals in the newly formed Acute Hospital Trusts. In primary care, there may also be the possibility of forging more productive relationships within Primary Care Trusts if Local Health Care Cooperatives see collaborative working arrangements being accompanied by transparency. The proof must be in the extent to which a new regime of co-operation and collaboration can secure achievements that were impossible within the strictures of the competitive market.

CONCLUSIONS

The main thrust of the analysis outlined above indicates that the NHS has yet again found itself in a period of both organisational and cultural change. This process of change has been predicated largely on the basis of perceived failings that were germane to the market-based approach. In spite of this, however, the architects of **Working for Patients** in 1989 might still see a degree of continuity as well as change. The key issue within the context of this more recent raft of changes is how to replace competition with collaborative structures that are able to deliver high-quality services within the context of continued resource constraints.

It is still, at this stage of the proceedings, rather early to make definitive judgements about the likely success of this most recent reorganisation, but it is illuminating, if nothing else, to be in a position to identify emergent issues that are likely to develop in years to come. Crucially, however, the most significant difference between this and the previous changes which were introduced into the NHS is that there has not been the same groundswell of opposition that accompanied the implementation of **Working for Patients**. This may in itself tell us something about the extent to which these changes might be more readily accepted, in that for the time being we have a broad acceptance that the fragmentation and mistrust that so often characterised the market needed to be addressed. It nevertheless remains to be seen how the success or otherwise of these changes will be judged in the fullness of time.

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