

SCOTTISH AND ENGLISH HEALTH POLICY FROM 1948 TO THE 1973 REFORMS: MANAGEMENT THROUGH A UK PRISM?

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INTRODUCTION

This article is an examination of English and Scottish health policy from the establishment of the NHS to the 1970s, exploring both areas of commonality and divergence. It focuses in detail on the years preceding the passage of the National Health Service Reorganisation Act and the National Health Service (Scotland) Act 1973. The period from 1968-1973 cover the policy initiation, formation and consultation phases of reform. This reform was highly significant in the NHS narrative; it was the first comprehensive government-initiated examination of NHS structures and management overall since the NHS creation. Although there were three Royal Commissions appointed since 1948 (on law relating to mental illness; on doctors' and dentists' remuneration; on medical education), only the Guillebaud Committee considered the NHS as a whole and its remit was cost.

A key objective of the article is to outline how and the extent to which a national UK wide framework for the health service ran alongside nation-(Scotland and England) specific approaches to policy, administration and management. The paper will set out common British roots to the late 1960s' drive for reform and analyse the way Scottish and English health systems approached the reform process.

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Use is made of key secondary literature on English and Scottish health policy, in addition to primary research material. Primary research used official documentation, including Health Department for Scotland files and Scottish Home and Health Department material in the National Archives of Scotland, along with documents in the Greater Glasgow Health Board archive and the Glasgow City Archive. Much of this material has only recently been released for public use. The paper's conclusion includes some brief comment on the post-1970s period, flagging some researchable issues and raising questions on current developments.

THE 1948 NHS SETTLEMENT: CENTRAL RESOURCING AND PROFESSIONAL INCORPORATION

There were two salient features of management and organisation from the creation of the NHS. First, there was a strong central rather than local government locus in administration, policy and funding. This was a policy direction won by Bevan against some serious opposition within the governing Labour Party, which was more sympathetic to local government control of health (Foot 1975). There was the centralisation of funding for health from the Exchequer and thereon in Scotland to the territorial administration in the Scottish Office. Allied to this of course was the fact that funding of health was interwoven with government macroeconomic policy and notions of affordability. Second, there was strong medical professional input into the management of the new service. The executive management of the NHS was entrusted at local level to Regional Hospital Boards and, for general practice, to Executive Councils, with the important condition that GPs were not employees but were categorised as self-employed contractors. These executive bodies, funded and appointed by central government, had executive authority with strong representation from the medical profession and gave representatives of the profession a key role in resourcing activity at local level.

Executive Management of NHS – Involvement of the Medical Profession

The medical profession was able to wield significant power at local level. For example, doctors played the most influential role in the selection and appointment of senior hospital staff. This appeared to have the effect of introducing a large measure of meritocracy into the system, in the view of

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J.W. Howie, Professor of Bacteriology at the University of Glasgow, and later President of the BMA:

Compared with the state of affairs before the NHS was initiated, the policy of selection and appointment of registrars by committee confers the great benefit of open competition for posts. There is no longer any question of patronage or of arbitrary selection or exclusion of candidates. In the past some chiefs may have had virtually sole powers in this matter, and I am glad that this state of affairs has ended. (GGHB, HB 16/1/5 1954)

Such meritocracy of course was very much professionally peer controlled.

Other key resourcing decisions were taken at local level. With executive control strongly influenced by the medical profession and funding flowing directly from central government, what in fact occurred was the incorporation of a key interest group into the decision-making process. As one authority explains, it represented 'professionals being turned into the state's agents for rationing scarce resources' (Klein 1995). Studies have shown in some detail such a process occurring at hospital board level (e.g. McTavish 2002).

Pressure on the 1948 Settlement

The two decades after NHS creation saw a substantial increase in resources devoted to health. Between 1950 and 1968, the current budget increased by 39% in the UK as a whole and by 45% in Scotland ((Merrison) Royal Commission on NHS 1979; Stewart and Mooney 1987). However, these figures should not lead to an overwhelmingly benign view of the macroeconomic health environment whether from a British or Scottish perspective. Macroeconomic policy in the 1950s and 1960s was geared to the maintenance of exchange parity with the dollar (at \$2.80 until 1967, thereafter \$2.40). Adverse movement in the balance of payments was a key signal for governments to tighten fiscal and monetary policy (Sentance 1998) and this influenced thinking on the need to continually keep any increased public expenditure under close scrutiny (Booth 2000). There was an impact on health-related capital expenditure programmes: the Guillebaud Report in 1956, in addition to noting the value for money which the NHS gave, pointed out that the NHS had been starved of resources for capital investment, claiming that the capital investment programme was running at a much lower level than even the pre-war hospital system (cited in Klein 2001, p.31). In

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fact in the first decade of the NHS, only one new hospital in Scotland was built (at Alexandria) and despite a 1962 Government White Paper (as a result of Guillebaud) and a capital programme, the pattern changed very slowly.¹ A key insider, Sir John Brotherston (and as Scotland's Chief Medical Officer, he would know), commented on the dispiriting impact on doctors when working in hospitals 'which by international standards were shoddy' (Brotherston 1987, p.105).

Macroeconomic factors meant that this situation was unlikely to change quickly and this would cause a strain in the 'incorporation framework'. Although the UK economy was growing steadily in the 1950s and 1960s, growth was at half the rate of its major competitors. This was partly explained by the lower starting point of many countries in war-ravaged European economies, but by the early to mid 1960s GDP per head in France and Germany overtook Britain's, already well behind the USA (Sentance 1998). By the mid 1960s, the percentage of national income devoted to health was greater in competitor countries (OECD 1977). Given the importance of the UK's balance of payments and the subsequent public expenditure and fiscal stability objectives at this time (Pain and Young 1996), it was most unlikely that substantial step change increases in resources of the scale required for significant capital programmes would be made available.

The strain placed on the incorporation settlement was accentuated because, at the same time, the scope for increased medical intervention in patient care was increasing. The consequent frustration was highlighted by the fact that, 'the medical profession's standards were international, so the contrast between what was affordable in a relatively poor country like Britain and in wealthier nations like the US became more glaring' (Klein 1995, p.76).

Certain options to confront the gap between expectations and resource were difficult. Clinician autonomy (an important element of the NHS 'settlement') meant it was not possible to examine clinical judgement procedures and

¹ *The slow rate of new investment in hospital build programmes can be explained in part by government approaches to public spending and concerns about expenditure growth. There was a very limited approach to planning of new build: the system used simply assumed that revenue consequences of capital schemes would be met: this led to caution and concerns about the growth of health care expenditure in particular over the 1960s and was reflected in the setting up of the Public Sector Planning and Control (PESC) system (Stewart and Mooney 1987).*

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processes despite an increasing number of studies highlighting the revenue saving potential of changes in this area – and indeed some successful attempts to achieve this in other countries. Although the ‘Cogwheel’ structure started to move in this direction, it did so cautiously and not comprehensively (McLachlan 1971).

The policy approach adopted by governments of the 1960s (both Labour and Conservative) was to address the dilemma through a belief in the power of ‘rational management’ and by improving the management of resources. In particular, it was believed that the tripartite structural arrangement for the delivery of health (i.e. the separate organisational structures for hospitals, GPs, local authority health services) was inhibiting the effective and efficient use of resources. A consultative document circulated by the Scottish Home and Health Department (SHHD) and mirroring views in the Ministry of Health in London outlined this:

The basic criticism directed against the existing organisation of the NHS is that the tri-partite division into hospital services, executive council services and local authority services does not make the most effective use of the total resources available to meet the needs of patients, which do not fall into three corresponding compartments but can often be met only by the joint efforts of different parts of the service. (NAS, HH 101/2283 1969)

Rationalism and a belief in rational management was key throughout the reform period. The language used in the Scottish White Paper captured this:

The promotion of health and the treatment of illness and injury are among the major concerns of all societies, and in advanced countries a complex technology is joined with a wealth of human and material resources for this purpose. The proper aims of the administrative structure of the NHS are to make the most efficient use of resources, allow advances in knowledge to be applied without unnecessary constraints, and give effect as far as possible to the rational priorities of the community as a whole. (SHHD 1971, para 55)

Even if clinical autonomy was an untouchable area, rational management and efficient use of resources were issues which in principle the medical profession could address (and did so) as a matter for debate and discussion with government.

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These universal factors impacted on both England's and Scotland's health spend. But although there was an emerging consensus for reform based on the principle of efficiency of resource management and unification of structures, elements of policy and administration were applied distinctively in Scotland and England. This can be seen in the decades from NHS establishment right through the reform process.

POLICY AND MANAGEMENT OF HEALTH IN ENGLAND TO 1973

In England there was relatively weak political and decision making machinery in the Ministry of Health. The Ministry had to exist alongside a continued local authority health interest, kept alive up to and through the 1968-73 reform period; indeed the issue of local authority involvement was part of the reform agenda. The Guillebaud Report in 1956 saw the local councils' role as crucial. Appendix A to the Report stated:

It is suggested therefore that the hospital service should take its proper place with other local health welfare and social services under the unified administration of the local authorities whose members are democratically elected by the public and who can be relied upon to provide an efficient and economical service. This would be in line with the history of the development of the health services in this country and also in keeping with our tradition of democratic government. (Gilliebaud 1956, Appendix A).

Health was not always accorded prime importance at peak political level. After Bevan became Minister of Labour in 1951, the Department of Health's responsibility was reduced and the Ministry lost cabinet status. It was not until Enoch Powell was promoted to cabinet in 1962 that cabinet status was restored, though Harold Wilson's first cabinet in 1964 excluded health. Only in the late 1960s when the Ministries of Health and Social Security were merged under Richard Crossman was permanent cabinet membership established. This status was perhaps mirrored in the civil service administration of health. Health was seen in the early NHS years as a relatively unattractive proposition for a civil service career and was therefore avoided by the high fliers needed to take the new machinery forward and negotiate strongly with the Treasury (Kogan 1969). All permanent secretaries

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at the Department of Health prior to the appointment of Sir Bruce Fraser in the 1960s were occupying their last career post; the firm civil service career path that existed by the mid 1960s whereby the majority of permanent secretaries had spent time at the Treasury had not been replicated at Health. The Ministry's difficulty in controlling hospital expenditure was commented on in critical terms by comparison to the Department for Health Scotland. In the early 1960s officials in the Treasury were 'struck once more by how close a grip the Department for Health in Scotland have on what is going on. They have a much closer knowledge of Scottish hospitals and activity there than one can expect from the Ministry of Health' (cited in Stewart 2003, p.399).

There was a strong degree of enthusiasm among the medical profession for many aspects of reform, particularly the idea of an integrated health service, in the belief this could strengthen the position of doctors. Rational management and efficient use of resources were issues which in principle the medical profession could address as a matter for debate and discussion with government. In fact some years previously (1958), without any external encouragement, nine leading medical organisations formed a committee under the chairmanship of Sir Arthur Porritt. The Porritt Committee in 1962 called for single unified health authorities located in each natural area of administration. The Committee realised that a unified structure could give the profession a stronger voice as well as a more integrated and effective delivery of health care. Porritt's findings were well received by the medical profession throughout the UK (Webster 1996). Yet the profession did not establish itself at the centre of the NHS planning system in England as a result of the reforms. Evidence taken in 1976-77 and published in the Royal Commission on the NHS Report in 1979 showed that, in contrast to Scotland (as will be seen below), there was no mention of the medical profession's involvement in the NHS planning system. The most salient feature of that system appeared to be its lack of transparency:

After listening to careful explanation by representatives of the DHSS about the planning and allocation of resources to health authorities, we remain mystified. We are bold enough to think that this is because there is some cloudiness in the Department's thinking about these matters which are as important as anything in the Department's care. ((Merrison) Royal Commission on NHS 1979, para 6.17).

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This was hardly surprising when a key thrust of the reforms as articulated by Sir Keith Joseph, the UK Minister responsible for Health, was to address management as fundamental to the reform process. Joseph was particularly enthusiastic about introducing management and managerial structures as well as placing individuals with management and business experience at key points in the system. Departing from the principle in the 1970 Green Paper that health authorities should be composed on a representational basis, Joseph's main criterion for selection was to be 'management ability', though this was rather difficult to implement. One of Joseph's civil servants apparently reflected this difficulty by asserting that

Once you had run through his friends you had no-one else – in any case you couldn't have 15 hard-faced businessmen running the Area Health Authorities (cited in Klein 1995, p.87).

Management consultants and academics were appointed (e.g. McKinsey Consultants and academics like Eliot Jaques). A key aim was to introduce a structure of managerialism, with managers responsible for units of accountability. His desire was to avoid the proliferation of key advisory committees under-written by the group executive or consensus management principle. He failed and the picture which has emerged from research based on government documentation was the impracticality of civil service attempts to implement unit management in the face of united opposition from the medical profession (Webster 1996).

The policy outcome was messy. The medical profession had some input to the policy process – inevitable with such a powerful group – but through a rather weak advisory system with very circumscribed professional engagement at the centre. The outcome was a structure of Area Health Authorities (AHAs) but with an intervening (lesser) number of Regional Health Authorities (RHAs) acting as executive agencies between AHAs and the Department of Health. There was a corresponding multi-tiered structure of medical professional advisory committees to appease professional interests. The civil service appeared to justify the Regional layer to avoid over centralisation and delay in decision making. For the medical profession there was professional input at delivery (AHA) and intervening (RHA) levels, but the fragmentation resulted in a relatively weak and circumscribed advisory system at the centre. That system was based on the Central Health Services Council (CHSC) and its Standing Advisory Committees. This

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structure existed prior to the 1968-73 reform period, had failed to make a significant impact and was designed as a much weaker body than the central advisory body created in Scotland in 1971, the Scottish Health Service Planning Council (SHSPC).

POLICY AND MANAGEMENT OF HEALTH IN SCOTLAND TO 1973

In Scotland the position could hardly be more different. The central government administration of health in the Scottish Office (the Department of Health for Scotland, later the SHHD) was relatively strong. The historically rooted nature of this central politico-administrative grasp has been well researched (Jenkinson 2002; Dingwall 2003). In parallel, the appetite and enthusiasm for greater local authority input was weak. The Cathcart Report in the 1930s saw the uneven nature of local authority provision as a barrier to uniformity. Added to this, the success of war-time central government led Scottish experiments in socialised medicine (like the Emergency Medical Services encompassing a grid of nationally co-ordinated hospitals with full specialist support in anticipation of war casualties and the use made of this capacity by the Clyde Basin Experiment, accessing the Clydeside industrial workforce to a 'nationalised' hospital service), gave credibility to a strong central administrative role post war. In fact, there was little in the way of 'interference' from local authorities. In some senses this was surprising given the pre-NHS involvement of councils in health. For example in Glasgow, the Corporation's Committee on Health stated in 1944:

The last two decades have witnessed a greatly quickened development in the personal health services and in the provision of municipal hospitals for the sick. The Corporation has taken a wide view of its responsibilities in hospital care and until the outbreak of war unhappily interrupted progress in building, the scope of hospital service was being rapidly extended – speeding up must take place after the war. (GCA, LP 1 / 163 1944)

The Committee Report then went on to list the scope of activity: 17 hospitals with over 11000 beds and running costs of £1,400,000 [i.e. at 1944 prices] and a staff of 5000. Three of the hospitals were teaching hospitals linked to the University of Glasgow, 'and in this way contribute to the nation's health

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effort' (Ibid). The Corporation had extended ambitions for the post war years too:

in spite of this provision, there is still insufficient hospital beds in Glasgow to meet the full needs of the city, but the additions now in hand go a long way to remedy the deficiency. Still further development will be undertaken as soon as labour and materials become available. Before the war the Corporation made arrangements for the purchase of a site at Mearnskirck to erect another large general and maternity hospital. (Ibid)

Hostility from local authorities to the idea of central government control of the NHS was expected by the most senior political figures in the post-war Labour government (Webster 2002). However, local research in Glasgow has indicated that co-operation between council and the newly created NHS was much more pertinent. The first chairman of the Western Regional Hospital Board, Sir Alexander McGregor, had been Medical Officer of Health for Glasgow since 1925 (McGregor 1967). While this may only signify the career movement of a capable and experienced individual, co-operation was more deep-seated. For example the system of admission to former local authority hospitals remained centred on the 'bar' at the headquarters of the Glasgow Corporation Public Health Department well into the 1950s (Tough 2000). The documented evidence suggests that in areas of shifting responsibility and ownership from local authority to NHS, professional and service delivery concerns were as important (if not more so) than concerns of organisational boundary.² A letter from a senior official of Glasgow Corporation to the Scottish Office Department for Health in 1947 made this clear:

² *In the 'spirit of co-operation' Glasgow lost a domiciliary medical service for the elderly. Using permissive powers in the 1929 Local Government (Scotland) Act, salaried doctors, nurses and support staff provided this service to Glasgow's elderly population. With the NHS in 1948 this had to be disbanded due to the BMA's hostility to a salaried service for GPs. Sir Alexander McGregor understood the calamity this represented but despite strong efforts could find no way of avoiding it. In the spirit of co-operation between the council and the NHS this was accepted without challenge (Tough 2000).*

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We [i.e. Glasgow Corporation] are responsible for the majority of hospital confinements – in addition, the Corporation is responsible for midwives. That means we are the main body dealing with maternity work in the city

You may be interested to read a paragraph which appeared in the 'Medical Officer' 16 August 1947 from Sir Allen Daley Chief Medical Officer for London County Council: 'Under the new act all maternity hospitals pass to regional boards. ... whether it will be possible for local authorities to establish their own maternity homes (as distinct from hospitals) as a social and not a medical function is doubtful but we should not be surprised if things develop in this way'.

You see how his thoughts are developing. It is to avoid such administrative development that I am particularly anxious that the maternity units and maternity hospitals should be integrated functionally. If this is not achieved, I think Sir Allen is right – *that local authorities will press for the establishment of their own maternity homes. This is not desirable ...* . (GCA, D-HE1 / 2 / (2) 1947; my emphasis).

With the post 1968 reform period – which co-incided with Royal Commissions on reform of local government – placing the question of local authority locus in health into the public arena, the professional medical view varied little between England and Scotland. When questioned by the chairman of the Royal Commission on Local Government, Lord Wheatley, about the justifiability of removing existing local authority health and welfare functions away from local councils, the British Medical Association (BMA) view was:

Yes, this would be justifiable. The variation in the quality of local government at the moment – I am not saying this with intention to disparage – is such that we feel that the functions which they should be carrying out are not uniformly or universally being carried out to the full. ((Wheatley) Royal Commission on Local Government in Scotland 1968, para 220)

You are up against the priorities of individual authorities who say 'we would rather spend this money on roads'. (Ibid, para 2224)

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The BMA made a similar submission in response to the Scottish Green Paper on health reform in 1969, stating that it 'opposed control of health by local authorities in any form'. (NAS, HH101/ 3754 1969)

The BMA's views in England were very similar. The main contrast with England was the minimal support in the wider policy community for local councils having a role in NHS management. The Redcliffe-Maude Royal Commission on Local Government in England opened up the possibility of placing the entire health service under unitary local government agencies. By contrast, the Wheatley Royal Commission on Local Government in Scotland rehearsed the arguments for and against local authority control of health but refused to make a recommendation. The prevailing view at the most senior levels of government administration can be seen in a letter from a senior civil servant in the SHHD to the Ministry of Health in London:

I tend to stand firm on the line that finance and planning make it essential for the health service to be the responsibility of central government and that elected bodies, i.e. local government, could not be agents of the Secretary of State. (NAS, HH101/3875 1967)

Senior politicians in Scotland were unanimous when they spoke of a 'functional relationship' between health and local government, not one of control or funding (Webster 1996). Councils themselves had no uniform view. Most County Councils supported the views of the Association of Scottish County Councils (ASCC) which in its submission to the debate on the 1968 Green Paper believed that 'local councils should run the NHS'. The written submission of the Association carried little detail – which of course is not to say that a detailed case was not made orally or in other ways (NAS, HH 101/3754 1969). Dumfries, Orkney and Selkirk did not support the ASCC's views. These councils supported unified health boards directly funded by SHHD as proposed by government. Town Councils varied widely, but perhaps the most interesting (and most detailed) was the submission from Glasgow Corporation. The Corporation did not argue for local authority control, but

felt that the lack of public participation in the planning and administration of the NHS has been to the detriment of the service. (NAS, HH 101 / 3754 1969)

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Glasgow's submission focused on representation on the proposed area health boards rather than on local authority control of health:

Area health boards cannot be representative if they only have 18 members. At least 25 members – and lay members should be elected.
(Ibid)

Much of Glasgow's argument was based on the integration of health and (existing) local government services:

One of the main criticisms of the Green Paper is that even if advantages were to accrue from the formal integration of the 3 branches of the NHS, this advantage could be outweighed by the disadvantage of separating health services from other social services such as education, social work, sanitary administration etc. The Corporation is even more concerned at the possibility of breakdown in co-operation between health visitor and social worker and between school doctor and school teacher than the continuance of an alleged lack of co-ordination between GPs and hospital consultants. (Ibid)

Other large city-based councils also focused on some elective element to the new area boards rather than bidding for control of health services – e.g. Aberdeen and Edinburgh (Ibid). The message was inescapable: central not local government was the only real player in the management of the Health Service in Scotland, testifying to the relative weakness of local authorities (Dingwall 2003). Consistent with this view was the evidence that the Treasury felt greater comfort in SHHD control of health in the 1960s, feeling that not only did they have tighter control over the hospital service than the Ministry of Health had over English hospitals, but it represented much better value for money than local authority spending on health and welfare services (cited in Stewart 2003, p.395).

The primacy of central government in health was matched by the key importance accorded to health within the politico-administrative structure of the Scottish Office in contrast with England. The Secretary of State for Scotland's permanent cabinet status and his territorial responsibility meant that the health service in Scotland always had a presence in the UK cabinet. Although the quality of that political representation has been questioned (see Mitchell 2003), the capability of the administration in Scotland has not. The Head of the Department for Health for Scotland/SHHD was seen as a staging

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post in the Scottish Office. John Anderson was recruited from SHHD, served as Secretary of the Department of Health 1956-59, became Secretary of the Scottish Home Department and in 1963 Chairman of the Board of Customs and Excise. When Anderson left the Scottish Health Department in 1959 Douglas Haddow, who had risen through the ranks of the Health Department, transferred to the Scottish Development Department in 1962 and in 1965 succeeded Sir William Murie as Permanent Under Secretary at the Scottish Office (Webster 1996).

There was a strong and deep incorporation of medical professionals into the Scottish health service resourcing and planning system. As indicated above, the profession was able to wield almost total control over a merit-based appointments system. There is also considerable evidence of the profession's ability to skew expenditure according to its view of the health service's needs. A paper produced by SHHD in 1963 (in response to the Wright Report on Medical Staffing) indicated the considerably higher than average consultant staffing in Scotland in relation to administrative grades and was in doubt why this was so:

There seems to be a major question here of priorities – disparity [re situation in the rest of the UK] has been evident ever since the figures became available after 1948. Regional Board in Scotland have chosen to devote a substantial part of their development money each year to the creation of new consultant posts. (GGHB 28/2/63 1963)

It can be argued that the substantial increases in the hospital service was arguably at the expense of the GP service: incorporation of medical professional interests was neither uniform nor comprehensive.

Given the stronger centralisation, the degree of professional incorporation and the lack of a political drive for the introduction of managerial reforms in Scotland (in the absence of a Keith Joseph), the response of the policy community including the SHHD to managerial initiatives (which was, for a period, UK policy) was negative, if not hostile. This was ironic in the sense that much of the intellectual rigour behind management reform was contained in the Farquarson Lang Report. Farquarson Lang was a senior figure in one of Scotland's health boards, but his committee contained few serious medical figures and this helped explain its lack of uptake (Webster 1996). However, the real significance was that the SHHD felt confident enough to openly challenge the key managerial assumptions behind

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Farquarson Lang – and by extension and implication Joseph’s attempted reforms. The SHHD view was:

Paragraph 12 of Farquarson Lang believed the advantages of a single channel of management and administration outweighed the public disadvantages and recommend that a chief executive post should be established at each type of board... .

Paragraph 14 – there are more fundamental difficulties in the use of chief executives to administer affairs of health boards. Other officers must be able to advise the board: it remains to be determined whether the execution of the board’s functions is most appropriately performed through a hierarchy in which relationships are essentially those of superiors to subordinates The rationale of the executive group is that a service pursuing a wide range of objectives with the help of a number of professions can be administered better by a multi-disciplinary group than by a single chief executive ... an executive group may provide a more suitable point of contact and communication with clinical divisions than a chief executive particularly since these divisions will include many doctors who are independent contractors. (GGHB, HB 28/2/5 1972)

Given the different environment from England, the policy outcome in Scotland was distinctive. Undoubtedly, a key plank of centralist thinking in Scotland was the greater enthusiasm among the medical profession for both a unified system and one which, with the creation of the Scottish Health Service Planning Council (SHSPC), provided a centralised focus for the involvement of clinician interest in health planning at the centre of government. Scottish GPs were happy to place their contracts with the new unified Health Boards and the British Medical Journal made known its views on the differing Scottish and English perspectives at the very earliest stages of reform, favouring the Scottish approach (**British Medical Journal**, 10 May 1969).

The creation of the SHSPC brought senior clinicians and others into the centre of policy and decision-making. The key driver was Scotland’s Chief Medical Officer Sir John Brotherston. When the NHS Royal Commission reported in 1979, while it saw the key features of the planning system in England as opacity and incomprehensibility, the description of the Scottish

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system was different; it was highlighted by consultation between clinicians and others:

Arrangements for planning differ in Scotland where at re-organisation the SHSPC was established with representatives of health boards, universities, profession and SHHD. In addition there are national consultative committees for the main health professions which tender advice to the Secretary of State through the Planning Council. The Council has played a major part in the development of priorities for the Health Service in Scotland. ((Merrison)Royal Commission on the NHS 1979, para 6.19)

But the autonomy of Scotland's health system had limits. The SHSPC as a centralised planning instrument which brought senior medical and other health figures into the heart of decision making processes was not entirely welcomed by Whitehall. The SHSPC's power (or potential power) was such that it took some time for the Treasury to allow the Planning Council to proceed, fearing that the role of SHHD would be eroded in matters of policy or expenditure. And it can now be seen in the context of wider UK health policy that the SHSPC was a body well suited to an environment of growth but constraint (e.g. in 1976) made it very difficult to operate at the clinical-resource interface, not being well suited to planning for constraint. Nonetheless the initiative was significant and SHSPC had notable successes over a decade or so. It undertook a wide-ranging study of the management of orthopaedic services ranging from administrative procedures to case management and liaison between medical and para-medical professions (GGHB, HB 55/M/54 1988a). It was also an initiative from the SHSPC that led to consultants' waiting times becoming available to GPs (GGHB, HB 55/M/54 1988b).

CONCLUSION

There were a number of pillars upon which the NHS was built in 1948 common to all parts of the UK. There were though key differences in the founding legislation, for example in the integration of teaching hospitals into the main regional hospital board framework in Scotland, but not England. This article has outlined a somewhat different trajectory for health policy in the two nations in the 1950s and 1960s and this was highlighted in the

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separate approaches to reform in the 1968-73 years culminating in legislation.

There were strong historical roots to this differentiation which pre-dated the NHS. For instance, the importance given to health in the Scottish administration and the conjuncture of central government and professional interests as elements of Scottish health policy and administration in the 1920s and 1930s has been well documented (Jenkinson 2002). The examination of policy management in the 1968-73 period had parallels, with a much stronger link between central administration and professional interests in Scotland than in England.

However the key feature of Scottish health policy and management was not that Scotland got its own way, but that Scottish approaches reached an accommodation with prevailing UK perspectives. Again, the historic roots and parallels are striking. The Cathcart Report in Scotland in the 1930s proposed a National Health Service for Scotland and 'helped lay the groundwork for the operation of a distinctive health service suited to Scotland specific health needs post 1948' (Jenkinson 2000, p.7). While this is true, important features of Cathcart's Scottish dimension (e.g. a GP led service) were ignored in the NHS legislation (Jenkinson 2002). So too with the 1968-73 period. In Scotland the thrust of the Farquarson Lang Report and the political drive to managerialism were largely side-lined in the early 1970s, but managerialism was nevertheless introduced in the 1980s, although rather differently to England and with less enthusiasm than the UK governments would have wished (McTavish 2000; Bruce and Forbes 2001).

The paper supports the 'relative autonomy' argument, indicating considerable freedom of movement by professional, governing and bureaucratic elites within Scotland to act autonomously as long as this was within British governmental policy parameters (Paterson 1994). It also indicates a degree of diversity and divergence of policy and practice within the UK 'union state' – a more accurate depiction of the UK than 'unitary state', as least as far as Scotland was concerned (Mitchell 2003).

The post 1970s period is 'research rich' in the context of autonomy and diversity within wider British health policy. For much of the 1980s and 1990s there was a strong politically, sometimes ideologically, driven approach towards health policy, not seen in such a sustained fashion since NHS creation. There is a significant literature on Scottish policy and practice in the

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1980s and 1990s (Hunter and Williamson 1991; Lapsley et al 1997; Bruce and Forbes 2001), but a fuller and more comprehensive picture awaits research on (yet to be) released government documents. Detailed research on this highly important period will provide some grounding and contextualisation to emerging questions in three broad areas. First, is there a greater prioritisation and focus on a 'public sector ethos' in Scottish policy and practice, perhaps evidence of a social democratic communitarianism? (e.g. see Paterson 2002). Indeed, it is now argued that the growing divergence in health policy between Scotland and England post devolution is largely values-driven (Greer 2003), accentuated by movement away from traditional health service values in England; others argue similarly for other fields of welfare policy (e.g. Player and Pollock 2001; Simeon 2003). Second, is Scotland simply incrementally extending autonomy to areas where there has always been room for separate approaches to England? To an extent this is an inevitable consequence of devolution since, as Stewart has pointed out (Stewart 2004), the main areas of devolved power are precisely those where much pre-existing autonomy existed. Third, is health in Scotland a strong illustration of the defence of professional and vested interests, underpinned by the accumulated experience of actors and agents in a small polity – with resonance to Hecló and Wildavsky's (1974) concept of village life? Interestingly enough some parts of the media³ and others couch the recent (mid 2004) Scottish Executive initiatives to centralise acute hospital services at the expense of local provision in such terms.

ABBREVIATIONS

GCA – Glasgow City Archives

GGHB – Greater Glasgow Health Board

NAS – National Archives of Scotland

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³ See for example, editorial and comment in **The Herald** 1 October 2004.

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