MANAGEMENT REFORM OF THE NHS IN SCOTLAND: ENGLISH PLANS, SCOTTISH INTERPRETATION?

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Introduction: The Force for Reform

Discussion of reform in the Scottish Health Service (SHS) a decade ago would have presented a sharp contrast with the beginning of the 1990s. From 1979 to 1985 the Service in Scotland had struggled to introduce a relatively minor organisational reform of replacing districts, the second management tier of Area Health Boards, with units of management.[1] The difficulties were in large measure a general lack of enthusiasm for reform of any sort and, consequently, any coherent strategy. Indeed, the position was very candidly exposed by the then Scottish Health Minister, Russell Fairgrieve, when he stated: 'Supposing Scotland was totally separate. You might well say 'Would you have gone ahead with a reorganisation'? The answer probably on balance might have been no. But with England having to do it we felt on balance we should do it.'[2]

This relatively relaxed view was soon to be expunged as a result of the major reforms resulting from the Management Inquiry Team (Griffiths) Report which focussed on England, but on which Scotland was not going to take an independent line. The reforms that Griffiths initiated marked the most significant reorganisation of the NHS since its inception in 1948. However, throughout the 1980s there have been on-going reforms such as compulsory competitive tendering, 'efficiency savings' and performance review, all designed to make the Service give better 'value for money'. The 1980s have not just been a period of major change for the SHS, but one of increasing convergence with England. At the end of the 1980s the government announced even more far-reaching reforms with the introduction of an 'internal market'. Perhaps significantly in terms of our present concern these reforms were introduced by the NHS and Community Care Act which covered both Scotland and England – a first for the NHS. Even the name of the SHS has been changed to "The NHS in Scotland". The management changes inaugurated as a result of Griffiths and the evidence of their impact will be reviewed below. A later section considers the general thrust of the internal market reforms, looks at associated management changes, and considers the implications of this for the Service in Scotland. Most of the changes discussed parallel events in England, and only difference will be highlighted. An argument that will be developed later on is that although the plans for reform have been virtually identical, there have been variations in actual practice

between Scotland and England. It should be mentioned, however, that organisationally Scotland does differ somewhat from England in terms of formal structure: Scotland has areas, England districts; Scotland has no regional tier; in Scotland there is no equivalent to England's Family Health Service Authorities, with Health Boards managing primary care; and certain national forums and advisory bodies are different in form.

The Griffiths Report: The Force for Change

The Management Inquiry Team was set up in February 1983 by the English Secretary of State for Health, Norman Fowler, to examine whether the resources put into the Service 'are managed efficiently and give the nation value for money.'[3] The report, which came out in November of the same year, echoed the government's views that the NHS was inefficiently and ineffectively managed when compared to the private business sector. Many doubted the validity of such a comparison, which was not based on any measures of performance, just observation of practice, but the Report contended that management in the NHS was in a poor state on almost every possible count. 'Above all', there was extreme difficulty in achieving change.[4] The answer to these various problems was management leadership to be brought about by the introduction of general managers who were to have overall responsibility for services and could give the Service direction.[5] In consequence, the consensus management approach which had given equal voices to medical officers, nursing officers, finance officers and administrators on management teams responsible for running the Service at various levels, and which to many reflected the pluralistic nature of the NHS, was to be removed.

The appointment of general managers was not, however, the only club in Griffiths' golfbag. For one thing, general management as a process had to be instilled at all levels within the organisation. In effect, Griffiths' view was that management was too firmly based on the function or profession, and this meant fragmentation and division. On top of this was the implicit argument that management in the NHS needed not only to be changed, but also strengthened.[6] Administration was to give way to management, and there was to be an extensive devolution of management responsibility to invigorate lower levels of the organisation. More broadly Griffiths was looking to bring about a change in the culture of the organisation so that it was geared up to serve its 'customers' rather than the interests of the providers of the service. Roy Griffiths subsequently admitted that this was at least a ten-year project.

While Griffiths is most closely associated with the introduction of general managers and general management, there were two other important strands to the recommendations. One was an attempt to try to separate the management of the NHS from politics by creating an NHS Management Board under a general manager to manage the English Service from within the DHSS.[7] The NHS was intended to move in the direction of nationalised industries.

Secondly, hospital doctors who largely dictate the use of resources were to become involved formally in the management of resources at ward level through the introduction of management budgets.[8]

The Introduction of General Management in Scotland

In June 1984 Scottish Secretary George Younger issued a consultation paper which stated that 'the general principles underlying this (Griffiths) analysis apply to the Service in Scotland'. So general managers were to be introduced into the SHS who would take on 'personal responsibility for the efficiency, economy and general quality of service delivered at their particular level.'[9] There were only two differences of any note from what had been proposed for England. In Scotland the introduction of general management was to be phased in, with changes in units occurring some year after the appointment of Board General Managers.[10] (The English circular, which also came out in June 1984, had a simple date for completion of everything – the end of 1985). The consultation paper, in effect, created a period to review arrangements for units. The other proposal for which there was no similar provision in England, was that Board General Managers were to be responsible to the Accounting Officer of the SHHD for Board finances, while generally being responsible to Boards for their management.[11]

The consultation process produced a very mixed, and not wholly favourable, reaction. Examination of the relevant materials[12] indicated that in at least half of the Boards, members and chief officers were generally happy with the status quo and saw no grounds for reform. The proposals were viewed, not entirely wrongly, as a threat to both the position of the Board and officers in the Area Executive Group. Even those Boards in which there was some support for the concept of general management – usually those facing difficulties with consensus management – found the consultation paper short on details. There was also widespread concern about 'divided loyalties' resulting from the proposal that the Board General Manager was to have an additional responsibility to the Accounting Officer of the SHHD for the Board's finances.[13]

Further down the organisation, the consultation process revealed serious misgivings about, and often outright opposition to, the proposals. Clearly many professionals and professional bodies were worried about losing managerial independence if they were to become managerially accountable to a lay manager. Perhaps most importantly what emerged from the consultation process was the absence of an agenda for reform of any sort within Boards. The move to reform the Service was certainly not going to begin as a grass roots' movement.

The consultation process had no real impact upon the resulting circular[14], which simply amplified what had already been set out in the consultation paper. So by the end of 1985 all Board General Managers had

been appointed. There was no major influx of new blood into the Service as at one time had seemed likely. In the case of the twelve mainland Boards, six of the Board General Managers had previously been a member of the Area Executive Group of their Board. Two others had come from other Boards and one from the English Service at Regional level, while the rest were outsiders to the Service. Only one came directly from the private sector.

The appointment of Board General Managers was only the first phase, and one of the first tasks that fell to the new managers was to review their unit management arrangements. In August 1985 the SHHD commissioned Coopers & Lybrand Associates to examine the options for introducing general management into units in Scotland. This study was based upon an examination of arrangements in four Boards, and also upon the response to the SHHD consultative letter of July 1985 asking interested parties for their views. The report was published in April 1986. It revealed some important shortcomings in the way units were organised and managed, despite the fact that they had been reformed just three years earlier. In particular, it was noted that units were a weak tier of management, normally lacking effective powers and with inadequate management structures and support for effective decision making. Such problems were often compounded by the existence of a large number of small units within Boards.[15]

To strengthen management at unit level the report endorsed the appointment of Unit General Managers.[16] However, it was recognised that Unit General Managers were not the complete answer to the problem. The function of units had to be clarified on a Scottish basis: 'The function of Area should focus on strategic matters; the function of units should focus upon operational management', although it was acknowledged that no sharp distinction was possible.[17] In addition, the report laid down certain structural principles that units should meet to ensure that they were large enough to be effective management entities and redeploy resources, clearly defined in terms of responsibilities and have a clear sense of identity.[18] In respect of their internal arrangements Boards were to be given a free hand, except that, to develop a corporate identity and to reflect the multi-disciplinary nature of the Service, a version of existing management teams were to be retained.[19]

After consultation on the Coopers & Lybrand Report in the form of a draft circular, the circular regarding general management at the unit level was introduced in August 1986.[20] This largely accepted and repeated the Coopers & Lybrand Report. However, one of the consequences of appointing Unit General Managers was to end the line management responsibilities of the Chief Area Nursing Officer, the Treasurer and Chief Administrative Medical Officer over unit staff who were now to be responsible managerially to the Unit General Manager. The circular, however, stated that all three posts be retained at area/headquarters level. These three officers were regarded as essential for providing a 'corporate approach' to management. Further, the Board members would require advice and information regarding these three

key functions, and all three retained certain statutory responsibilities. Somewhat significantly, they were to retain the right of access to the Board regarding professional matters, and in various guises were to remain professionally responsible for staff within their function. Thus two lines of accountability were created within Boards: managerially through general managers; and professionally through professional officers, with the Board acting as the final guardian of professional accountability.[21] These provisions, which were not adopted in England, were seen by many general managers to be the result of a rearguard action by the professions within the SHHD to defend their positions in the new era of management, and flew against the spirit of general management.

In the first quarter of 1987 Unit General Managers took up their posts, and changes were made to management arrangements. This was an unsettled period for the SHS with the responsibilities of many management posts being shifted about or redefined, and a number of people having to apply, not always successfully, for their 'old jobs'. As with Board General Managers, there was no influx of outsiders into Unit General Manager posts. Of the Unit General Managers appointed around three-quarters came from within the SHS, although many found themselves moving within and between Boards. Only 10% were outsiders to the NHS.[22] The new cadre of general managers was created largely by appointing 'the best' of those who were already within the Service. Moreover, most came from administrative backgrounds; the professions were very under-represented.

The introduction of general management in Scotland had been conducted in a very mechanistic manner with little flair and imagination, and sometimes not much guidance either. The SHHD was seen by many to be not very enthusiastic towards the reforms that it was overseeing. Thus those general managers taking up the new posts in 1985 and 1987 found themselves squeezed between a lack of direction and strategy from above and considerable suspicion from staff below. (Indeed, many saw general managers as the agents of a hostile government put in place to oversee cutbacks.) In these circumstances the first year or so of unit general management was a particularly difficult period all round, with often faltering progress. Nonetheless, general management did finally find its feet and began to bring about the changes it was introduced to achieve.

The Impact of General Management in Scotland

Looking back to time before general management it is hard not to conclude that the reforms have had a major impact, at least upon the management of the Service. What impact it has had on the services themselves is far more difficult to determine.[23]

Escaping the Past

The results of general management in the early years were strongly influenced by the agenda adopted by general managers. At both Board and unit levels, general managers were concerned to remove what had been viewed as the main weaknesses of the old, consensus arrangements. These were slow and compromise or 'lowest common denominator' decision-making, a lack of follow-through to see that decisions were put into effect, weak financial management and an absence of a sense of direction represented in objectives and plans. Many of these problems have been cast aside by general management. Decision-making, led by general managers, is now sharper, more dynamic and quicker. Boards and units are now able to dispatch much more business, and can be seen to be operating on a much wider front of issues than previously. There is also a clearer allocation of responsibility, improving financial management and greater use of formal objectives and plans.

It is important to stress that sharper decision-making has seldom had to be achieved through general managers adopting the role of an arbitrator or 'boss figure', pushing through decisions against opposition. Instead, general managers have supplied leadership, a sense of direction, clear allocation of responsibilities and the creation of momentum. A particularly significant change is that decision-making has become much less formalised, with the general management working through individuals or groups of relevant staff on a project basis. There is much less work done in committees and formal teams. In many instances this leaves general managers free to delegate responsibility and simply monitor results. General managers – especially Board General Managers – are seldom involved in all aspects of decision making, a criticism made of the old consensus teams.[24].

The reforms were intended to do more than add a bit of zip to decision making and make the shift from reactive administration to proactive management.[25] The establishment of general management at unit level, after some initial hesitancy, has seen a noticeable strengthening of management closer to point of service delivery, aided by the delegation of budgets to units and the establishment of operational planning. The result of this is that service developments can be brought about more quickly and that there has been a much greater focus on the non-clinical aspects of quality of service. However, as we shall see presently, this strengthening of management in units has tended to rest at the top; there remain cases of weakness at middle and clinical management levels.

One problem that many expected would arise was the integration of professional officers into a general management system. General management clearly represented a demotion in the position of professional officers. At area level, the evidence is that professional officers have for the most part been effectively integrated into the new management arrangements, although some

'early retirements' helped to pave the way for this. A surprising number of Chief Administrative Medical Officers, Chief Area Nursing Officers, and Treasurers, while recognising that formally their status has declined, have welcomed the changes. This view reflects that many believe their actual influence on events has increased. Freed from line-management responsibilities, and often given responsibilities beyond their formal position, they have been able to play a greater role in managing the Service.[26] In other words, professional officers, most obviously finance officers[27], have been able to take on a quasi-general management role. However, while their personal influence on major issues has increased, that of their profession's voice has declined.

The position has been somewhat different at unit level. There, professional officers, who usually maintain line-management responsibility, have tended to find it less easy to slip into a quasi-general management role. Indeed, many Unit General Managers feel frustrated that they do not receive the kind of back-up from other unit officers that can allow them to concentrate on the key issues.

The integration of professional officers has been achieved despite the potential difficulties of dividing professional and managerial accountability. The division is, however, in reality a nebulous one; most of the time it is impossible to distinguish between the managerial and professional elements of an officer's work. In practice, largely informal and cooperative relations between general managers and professional officers at both Board and unit level have meant that possible conflicts have seldom arisen. This must in considerable measure be put down to a largely shared (or flexible) view about the Service and where it is going among officers and managers.

Looking to the Future

The above can be seen to indicate that general management has been successful in that it has worked, despite what the army of doubters argued in the mid 1980s. There are now very few voices who would argue the case for a return to the old consensus management. It needs to be stressed that the acceptance of general management is not universal, and many staff still have doubts about how it operates in practice, and even more are unhappy about a number of government-led developments which general managers had to implement.

Moreover, the success is far from absolute. In part, it should be remembered that general management was seen as a long-term transformation, and the process of development continues. More importantly, there has been a failure to progress effectively in some directions indicated by its original sponsors. In addition, there have been some negative side-effects. General management has proved very successful at displacing the old management arrangements, and has made a new version work; but it has yet to

prove conclusively that it can move beyond simply improving operational management processes to create wider change.

One shortcoming of general mangement has been the failure to develop a longer strategic vision of where services should be going within their area. The NHS for decades has faced the big planning issues of how to balance services equitably among different care groups, for example, to make proper provision for the frail elderly and mentally handicapped, and meet the needs for health promotion and prevention. General managers have failed to get to grips with these, in large measure, it must be said, because political debate on the NHS has become fixated with acute and child health services. Nonetheless, more was expected of general mangement to see through long-term strategic policy changes. A related area where general management has not developed as many would have hoped is its strategic capacity. According to circular 1986(Gen)20 the function of area level was to be 'strategic management'.[28] In practice, area has significantly retained a "headquarters supervising, overseeing' function, and not fully shifted to an 'area guiding, planning' role. There are a number of reasons for this: the increased place of monitoring and control, and general assessment of performance; the large number of initiatives from the central department which squeezes Boards' agendas and deflects attention from the long term strategic issues; a general absence of an overall conceptualisation of what a strategic role at area would look like; and difficulties in organising strategic planning effectively.

If general management has not made the expected mark strategically, it is also generally recognised that there have been limits to the extent to which general management has extended down the organisation. The appointment of Board General Managers and Unit General Managers represented the first stages, but a wider general management process and approach by individual managers was supposed to develop further down the organisation. While the process of extending general management has never come to a complete halt, it is clear that in many Boards general management did get stuck at or around the level of the Unit Management Team. Thus middle management in units continued to operate under the old-style, functional management. The result of this appears to be that there is insufficient leadership at middle and 'front-line' levels, and this has limited the scope for achieving change on the ground. Only recently have general managers begun to get to grips with developing structures of 'sub-unit general management'.

The limited extension of general management downwards has been mirrored by the restricted involvement of doctors in management. This was one of the central planks of the Griffiths Report, and was echoed by the government.[29] Management budgeting, the original means for drawing hospital doctors into management, was abandoned after the pilot sites in both England and Scotland had failed to work and had generated adverse reactions among clinical staff. While management budgeting was replaced by the more flexible initiative of resource management[30], there was little immediate

progress in Scotland. Involving doctors in management is a delicate matter confronting matters of professional autonomy, and without any real impetus and support from the central department, Unit General Managers had to adopt a softly, softly approach to bring doctors into management, with the emphasis upon building support before moving to make changes. Given that it was a high-risk exercise, and seemed to carry little priority at the centre, it was hardly surprising that Unit General Managers did not rush into creating structures to draw doctors formally into the management of resources.[31]

General management may not have moved forward on all fronts, but there has not been a lack of activity – rather the opposite is the case. Boards and units have been able to initiate a major series of changes. There remains concern, however, that, while the flow of developments and initiatives has increased, there is inadequate time to bed them in properly and to provide the necessary follow-through to ensure that they produce the intended results. General management may have increased the policy-making capacity of Boards, but as the discussion on the extension of general management down the organisation implies, there may not have been a commensurate increase in the capacity to implement and review the impact of policies. Similarly, there is concern that what exists now is not quick decision-making, but rushed decision making with inadequate time for proper analysis of issues. Most worryingly, there has emerged a trend, under the continual pressure to bring about change, of managers increasingly making short-term, high profile innovations and initiatives which give the appearance, but not always the substance, of change. In the new management culture and the increasingly high political profile of the Service, public relations in a wide sense has become increasingly important.[32]

Without doubt the most serious impediment to general management has come from the SHHD's failure early on to embrace the spirit of Griffiths that general management should be accompanied by greater devolution of management responsibilities. The NHS has always tended to be bureaucratic, but the arrival of general management saw the removal of many rather petty rules and regulations. The SHHD did, however, find it difficult to let go of the reins, and continued to make demands for considerable amounts of information for monitoring purposes and to intervene widely. This has been compounded by an obvious failure to give a clear strategic lead and to set out priorities. Indeed, as one Unit General Manager remarked about the SHHD, 'everything is a priority'. The result is that Board and unit agendas tended to become over-burdened and lack coherence, while the flexibility enjoyed by local management is not commensurate with the job that general managers were supposed to carry out. The balance between the centre's roles of providing broad strategic policy guidance and that of monitoring and control, was felt by many general managers and others to be seriously skewed.[33] Part of the problem was seen to lie in the small number of senior civil servants in the SHHD, combined with high turnover, which meant it was not equipped to act as the executive board for the NHS in Scotland.[34] General management was

most lacking from the Service right at the very centre.

Reform Again: The Internal Market

Just as the pattern of general management in Scotland was taking shape, including its strengths and shortcomings, and the needs for future development were emerging with some clarity, the NHS embarked on even more far-reaching reforms. In January 1989, following a lengthy review of the NHS led by Prime Minister Margaret Thatcher, a White Paper *Working for Patients* was issued[35] The main plank of the reform was to split the NHS into two distinct parts: purchasers of services and providers of services, thereby creating an 'internal market' in care. The purchasers were to consist of Health Boards and those larger GP practices which opted to become fundholders who were to purchase care on behalf of those people on their practice lists. The providers were to be made up of: Health Board units – the so-called directly managed units; NHS self-governing trusts – separate authorities under the direct control of the SHHD; and private and voluntary providers. When the White Paper was published there was considerable comment in the SHS that the reforms were not relevant to Scotland, but were reforms for the Health Service in London. However, Scotland has undergone virtually the same package of changes.

The idea of the internal market is that purchasers of care will be able to shop around to purchase the best in terms of price and quality. Logically a hospital could go out of business.[36] Therefore, there is a direct pressure on those hospitals and services that are comparatively costly or of low quality to improve 'performance'. To work, however, the market will require that there is a choice of different suppliers of services, and that there is or can be found excess capacity to allow the provision of care to be moved about to get the 'best buy'.

There has been much speculation as to how the 'internal market' will operate. What has become clear is that nobody fully knows because it depends greatly upon how the various actors decide to behave. For example, will Health Boards be inclined to buy cheaper health care at lower levels of quality to reduce waiting lists, or will they seek to maintain standards? Will hospitals act in consort or competitively? Are people willing to travel further for better care? In any case, the market is likely to operate differently in say Inverness or Dumfries than in Glasgow or Edinburgh. What is evident is that the market is to be introduced gradually. The talk from the central department for a year before the reforms arrived was of 'soft landings' and 'no bumpy rides'. Most people accept that it will take at least three years before the market is properly operational.

Whatever the ultimate impact of the internal market, the White Paper will lead to important changes in the management of the Service. For one thing there will now exist a much sharper division between the role of Area Boards

and units, even although those units which are not trusts will still be managed by Boards. Greater delegation to units has occurred and the headquarters of Boards are being reduced considerably in terms of staff numbers. Greater autonomy for units in line with trusts are the way forward.[37] In the longer run, the continued viability of Area Boards is open to doubt. It is increasingly recognised that Areas are probably too small entities geographically to perform a strategic role. Certainly, there could be a logical reason for amalgamating a number of them, although much depends on whether the view prevails that purchasing should be informed by local needs or the use of organisational muscle to put pressure on providers. The case for amalgamation would be increased greatly by the creation of a large number of trusts.

Given that the purchaser/provider split has led to delegation to units, and will require units to operate business plans and deliver on their contracts with purchasers, the reforms have given considerable impetus to strengthening middle management within units and drawing doctors into management. What a hospital provides in terms of services is going to be much more clearly specified, and costed, and the management structures based on particular services such as maternity or general surgery, are having to be developed so that contracts can be agreed and delivered. Part of this process has involved deciding to introduce resource management throughout Scotland by the end of 1992.[38] This will, among other things, provide the information systems that will allow for costing of services and bring clinicians more directly into management.

Two other major management changes have been inaugurated by *Working for Patients*. One is the establishment of a Management Executive for the NHS in Scotland; the other is the reconstituting of the membership of Health Boards.

Working for Patients announced that 'it is desirable that the management of the Health Service should be strengthened and the Government has decided to appoint a Chief Executive for the NHS in Scotland'.[39] Similar proposals were put forward for England. There was no doubt that a 'general manager' at the central department was something that was widely welcomed by general managers. In October 1990, Don Cruickshank, a Scot who had been chairman of Wandsworth health authority and managing director of Richard Branson's Virgin Group, was appointed. The appointment generated some fears of a 'business take-over' among many Service staff. The role of the chief executive has become defined as: securing the implementation of policies; strengthening management within the SHHD; providing central leadership for the reforms; and the formulation of a sustainable strategy and development plan for the Service.[40] Policy making was to remain, however, firmly under the control of ministers. In addition to the chief executive himself, a Management Executive was established consisting of six directors and the Chief Medical and Nursing Officers. The six directors were: strategic management; health services

operations; finance; manpower; administration; and a director to oversee the reforms. In addition, a number of divisons of the Common Services Agency was brought within the Management Executive.[41] The chief executive is personally accountable to ministers, and acts like any other civil servant on behalf of ministers.

It is too early yet to assess the impact of the Management Executive. All that one can say at the moment is that much of its work has been caught up with the NHS reforms. There has, however, been some concern expressed within Health Boards that the kind of leadership being sought has not been provided and that it has become too closely connected with monitoring.

The second change announced in *Working for Patients* was a change to the membership of Health Boards. This was to make Boards smaller in numbers, and to change the sources of recruitment to 'reflect the changing requirements'.[42] Part of the changed role was to provide greater strategic leadership on long-term issues. Boards are to have no more than 12 members, less than the norm of 13-19 members prior to the changes. There will be two categories of members, executive and non-executive, with the latter always being in a majority. The only guaranteed executive member is to be the Board General Manager, although it is expected that in most Boards the Treasurer and the Medical Officer/Director of Public Health will be members.

The role of the Board is to change significantly, becoming much more explicitly a managerial body and largely losing any pretensions – appointments to Boards were increasingly political – to being one that is representative of the local community. Non-executive members in effect are to be chosen in most cases because of their business management experience. Collectively the Board is to set key objectives and policies, and determine management structures. In addition, non-executive members are to monitor and oversee the implementation of policies. Individually, the chairman is to provide leadership, represent the Board to the outside world and direct the work of non-executive members.[43]

While Boards will principally act as purchasers of services by negotiating contracts with providers based upon an assessment of the health needs of their population, they will also retain a responsibility for managing their own units which are not trusts. However, it is clear that, if not immediately, then increasingly, there is a requirement to take a 'hands-off' approach which both allows units to become trusts, and allows Boards to purchase from units or trusts in other Board areas.[44]

These developments stemming from *Working for Patients* probably will contribute to a strengthening of general management within Scotland, although how far and with what side-effects remain to be discovered. In many cases they are a logical development from the earlier reforms. Central direction through the Management Executive was certainly much needed by

general managers. Much will depend upon how far government and the department can go along with their own rhetoric of 'local management' and how far the pressure to intervene and control will remain. There is little doubt that the reforms have further strengthened the hand of managers and diminished the formal position of professional officers. Such developments generate considerable unease more broadly within the professions who are concerned that the professional dimension is getting squeezed out of decision-making at all levels. The NHS is becoming much more like a business run by a professional corps of managers; and much less like a public service managed by professionals. The doctors do, however, retain considerable autonomy from management, although many felt the net is closing in on them. The internal market will weaken their position, but not to such an extent that they will cease to be a key partner in decision-making.

Reforming the NHS: An Overview

The 1980s were not a period of paper reforms for the NHS in Scotland. Unlike previous reforms in the NHS, which tended to introduce a new structure and then leave people to get on with it, the present reforms have been designed to be ongoing and sustained. This will continue under the NHS and Community Care Act and the internal market. To date there has been little public support for these new reforms, and many in the Service are suspicious of the direction being taken and the rhetoric espoused. The most controversial part of the reforms, has been the possibility of units becoming self-governing. By August 1991, six out of 53 units in Scotland had or were about to make applications to become self-giverning, although some seemed to be doing so because their position was in jeopardy (echoes of what happened with schools).[45] In most cases hospital staff were largely opposed to the change of status. However, if there is no change in government then the spread of trusts is likely to grow rapidly as their financial advantages will make it a club few can afford not to join. The freedom that trusts might enjoy – assuming the SHHD takes a hands-off approach – will allow for significant changes to be introduced in Scotland's hospitals. The extension of a business management approach will move forward markedly and quickly. However, it should be emphasised that overall these are long-term reforms, requiring the development of new financial and support systems. Keeping the momentum going will not be easy.

The development of the new changes will also see in formal terms a growing convergence of the SHS with its English counterpart. Over the 1980s the policy and managerial independence of the Service in Scotland has diminished. With one or two relatively minor exceptions it is now hard to discern a distinctive Scottish health policy. Scotland effectively follows what is planned for England, not just in general terms but in much of the detail. The centrally directed diminution of Scottish independence, however, has not so far been fully reflected on the ground. The evidence from comparative work in Scotland and England[46] indicates that the impact of general management in Scotland has been more muted, noticeably less 'macho', than in England.

There has also been less overt conflict between managers and professionals, and a more consensual approach in evidence. With exceptions there is a difference in management style which is noticeable, and a more traditional view of the Service retained in Scotland. There is also some evidence that Scottish managers have a broader, less finance-led agenda. In sum, these reforms have clearly not been driven so hard or fast through Scotland, and probably have not been able to travel so readily in the Scottish environment.[47] There is some evidence that the latest reforms are not proceeding as quickly as south of the border.[48] The more lenient atmosphere in Scotland in part is no doubt due to the funding levels enjoyed in Scotland, 23% per capita above the English average. (This crude figure should not be taken to indicate that Scotland is better-off by a quarter). Likewise, the point that Scottish units are larger on average has probably created some barriers in terms of size for the achievement of change.

At the end of the day, however, one is drawn to evidence that there is a distinctive Scottish 'culture' that has taken out some of the fizz of the reforms, and even ensured that less fizz was put in in the first place. Of course, culture can be a nebulous, catch-all concept. Scotland does, however, vote differently from England, and Scotland as a country has not embraced many of the Conservative Government's initiatives as warmly as south of the border. It is hardly surprising if this does not impinge upon the way public services are managed. This is a point highlighted by Laurence Peterken, Greater Glasgow's General Manager, when he stated that: 'One always gets painted with a black brush if you're changing anything in the NHS in Glasgow and perhaps Scotland generally, where there tends to be a fairly left of centre trade union orientated attitude to life.'[49] The Service in Scotland has been less welcoming of the business ethic. Formally and officially Scotland is more or less identical to England. In this sense, the reforms have followed English plans. Informally and unofficially Scotland has not moved so quickly along the road. There has been a Scottish interpretation.[50] Whether this unofficial 'devolution' will last is not certain.

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August 1991

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2. *Health and Social Services Journal*, April 3 1981, 375.
3. *Hansard*, 1983, col.181.
4. *NHS Management Inquiry* (London: DHSS, 1983) See also D J Hunter and P J Williamson 'Perspectives on General Management in the National Health Service', *Health Services Management Research*, Vol2 (1989), pp 6-8.
5. *ibid*, pp 4-6.
6. T Evans Griffiths, 'The Right Prescription?' London: *Chartered Institute of Public Finance and Accountancy/Association of Health Service Treasurers, 1983*.
7. *NHS Management Inquiry*, pp 3-4.
8. *NHS Management Inquiry*, pp 6, 18-19.
9. *SHHD The General Management Function in the National Health Service in Scotland: Proposals for Discussion* (Edinburgh: SHHD, 1984), Section. 2.1.
10. *The General Management Function in the National Health Service*, Section 3.1.
11. *The General Management Function in the National Health Service*, Sections 4.2, 4.4 and 4.5. The result was that the BGM would be delegated part of the Accounting Officer's authority, and have to respond to the Secretary of the Department on all matters concerning financial management and propriety, as well as being answerable to the Comptroller and Auditor General. This would include accompanying the Accounting Officer to the Public Accounts Committee (PAC) to answer matters on the Board's performance, the BGM being the signatory of the Boards accounts.
12. The concussing reached here are based on an examination of the materials prepared by 14 of the 15 Boards regarding the reforms. Included are the official submissions, internal discussion papers and documents prepared as part of the process of internal consultation.
13. This was mentioned by 11 of 14 Boards whose materials were examined.
14. *SHHD General Management in the Scottish Health Service: Implementation – The First Steps Circular 1985* (Gen) 4, 8 March 1985.
15. *General Management in the Scottish Health Service: Application to Units* (Edinburgh: SHHD/Coopers & Lybrand Associates, 1986), pp 11-16.
16. *ibid*, p 17.
17. *ibid*, p 19.
18. *ibid*, pp 25-26.
19. *ibid*, pp 23-24.
20. *General Management in the Scottish Health Service: General Management and the Development of Senior Management Structures*, SHHD Circular 1986 (Gen) 20, 25 August 1986.
21. *ibid*, pp 5-10, 18-19 and 35-38.
22. 'The new UGMs – an analysis of management at unit level'. *The Health Service Journal*, 2 July 1987, Centre Pages.
23. Much of the evidence for this section draws on a research study conducted by the author. Further details are available in P J Williamson *General Management in the Scottish Health Service* (Aberdeen: Department of Community Medicine, University of Aberdeen 1990).
24. *ibid*, pp 18-19 and 36-38.
25. S Harrison, D J Hunter, C Pollitt and G Marnoch *The Impact of General Management in the National Health Service* (Leeds/Milton Keynes: University of Leeds, Institute of Health Services Studies and Open University, Faculty of Social Sciences, 1989), p 2.
26. Williamson *General Management in the Scottish Health Service*, pp 55-62 and 72.
27. P J Williamson 'Broader horizons for finance officers', *Public Finance and Accountancy*, 28 September 1990.
28. 1986(Gen)20, para 6.

29. *The General Management Function in the National Health Service in Scotland*, paras. 7.1-7.2; and 1985(Gen)4, para.19.
30. C J Pollitt, S Harrison, D J Hunter, and G Marnoch, 'The Reluctant Managers: Clinicians and Budgets in the NHS', *Financial management and Accountability*, Vol 4 No 3, pp 213-233.
31. Williamson *General Management in the Scottish Health Service*, pp 50-52.
32. *ibid*, pp 70-77.
33. *Ibid*, pp 8-9, 39 and 73-74.
34. Circular 1985(Gen) 4 had proposed setting up a Health Service Policy Board, (para. 5). The work of the Board is most noted for its absence. In part it was constituted in a manner that gave it no base for doing the necessary management work. Likewise, it was the kind of body that was vulnerable to interventionist ministers.
35. London: HMSO, 1989.
36. In terms of political logic it is unlikely that any government would allow an NHS hospital to close unless it was held that there was excess capacity or it needed major capital redevelopment (ie that it would probably be closed anyhow).
37. *Health Circular SHHD/DGM (1990)* 16, 7 March 1990.
38. *Health Circular SHHD/DGM (1989)* 100, 21 December 1989.
39. *Working for Patients* p 80. See also *SHHD Resource Management in Scotland Circular SHHD/DGM (1989)* 100, 21 December 1989.
40. Letter from Chief Executive to Board General Managers, 1 March 1990, pp 1-2.
41. Letter from Chief Executive to Board General Managers, 1 March 1990, pp 7-8.
42. *Working for Patients*, p 81.
43. The Functions and Structures of the New Health Boards, Letter from Chief Executive to Board General Managers, 13 September 1990.
44. The Functions and Structures of the New Health Boards, pp 1, 7-8.
45. *Scottish Office, National Health Service Management Executive, Unit Structures and General Management at Unit Level Circular 1991* (Gen)4, 31 January 1991.
46. The discusion here is based upon joint work being conducted with Dr David Hunter who was involved in a major study of general management which included two Scottish boards.
47. P J Williamson 'Lead and Follow Through', *Health Services Journal*, 19 July 1990, p 1068.
48. Proportionately there are fewer units expressing an interest in trust status and develoments have been slower than in England. The first trust will not be established until a year after England. Similarly there has been a low level of response from GP practices looking to become fundholding purchasers on behalf of their patients. Only five practices in Scotland have expressed any interest.
49. T Delamothe 'Glasgow: city of managerial culture', *British Medical Journal*, Vol 301, 29 September 1990.
50. D J Hunter and P J Williamson 'General Management in the NHS: Comparisons and Contrasts Between Scotland and England' *Health Services Management*. Forthcoming.