Letter from Westminster

Tips from across the border

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The new arrangements for ensuring better accountability in the NHS announced recently by Mr Norman Fowler (30 January, p 364) were prompted by criticism of the DHSS in a report published in July 1981 by the Public Accounts Committee (PAC). The new system, which will be set up over the next year, consists of Ministers holding an annual review of priorities with RHA chairmen and chief regional officers. The aim is to ensure that each region uses the resources allocated to it in accordance with the Government's policies—that is, giving priority to services for the elderly, the handicapped, and the mentally ill.

The announcement has been generally hailed as a step in the right direction. Trying to make head or tail of it meant going back to the PAC report, and I was struck by the fact that it repeatedly drew attention to the different practices in Scotland, where the NHS is a separate institution with its own Minister. The report commended quite a lot of the practices to the DHSS so it seemed worth asking the Scottish Health Minister, Mr Allan Stewart, why it was that some things seem to be better done in his part of the world.

Mr Stewart, who got the job in last year's reshuffle, is MP for East Renfrewshire and a former Scottish director of the CBI. He reckons it is the scale of the operation that provides the benefits. "There are 15 health boards in Scotland, and that means I can meet them to talk over their problems," he told me. "It also means my officials in the Scottish Home and Health Department can meet the secretaries and treasurers of boards easily and that close relationships are built up—people know each other."

He illustrated what he meant a little later during our talk in his palatial office in Dover House—one of Whitehall's better buildings—when we started to discuss value for money in the NHS. I asked about the possibilities of introducing outside contractors to run such hospital services as laundry, cleaning, building maintenance, and catering, given that it would be easier in terms of scale to do so as an experiment in Scotland. "Gerry Vaughan put out a circular about that," he said, referring to his English counterpart. "I happened to be having a routine meeting with my board chairmen so I used the chance to tell them I wanted the possibilities reviewed. They are going to report back about what they find."

He repeated the point about the smallness of Scottish society. The community actively concerned in politics and current affairs is relatively small, which means that people in public life keep running across each other. He believed it would be possible to experiment more easily in the Scottish NHS than in England, again because of the scale of the operation. It simply would not cost as much. He would not rule out taking the initiative, as the Scottish Office has done in other areas of social policy for which it is responsible, but not just for the sake of doing so. As for contracting out, while he recognised it had contributed to cutting

costs elsewhere in the public sector, he believed that cleaning an office block was not the same as cleaning a hospital.

Mr Stewart, who is also a former university economics lecturer, has no medical background. In that respect he differs from some of the recent incumbents of the Elephant and Castle. There are two sides to the argument about whether specialised knowledge is an advantage for a minister or a dangerous thing, and he is in no doubt about which side he is on. "I don't see it as a disadvantage," he said. "I think what I have is a management role. Decisions come up and you have to exercise your judgment. The SHHD provides the professional advice, and I do not believe my job is to duplicate that. I am there to exercise judgment on overall strategy and on particular problems in relation to Parliament." So far, he reckoned, nobody had tried to bamboozle him with medical expertise, and he seemed convinced that he would have recognised it if they had.

Differences of approach

On the whole, he considered that the SHHD should operate in parallel with the DHSS and not develop in a radically different way unless there was a good reason for doing so. But there were differences of approach. Private beds, such a cause of strife in England, were not a great issue in Scotland because there were so few of them, and there were other differences. In Scotland the health centre is a well-regarded institution, and Mr Stewart believed that patients were largely satisfied with team practices operating from custom-built centres. That is not the case in England, where the health centre is distinctly out of fashion and money is no longer earmarked by central government specially to encourage their construction.

Scottish health is far from good—alcoholism, smoking-related diseases, and heart disease are all serious problems—and in the run-down industrial areas of central and west Scotland the general level of people's health is not good.

On smoking, he was particularly pleased about a sponsorship deal set up with the Scottish world cup squad—potential folk heroes. In return for some financial help from the Scottish health education group budget some of the leading players will expound the benefits of not smoking. He saw the deal as imaginative and reckoned that it would—again because of the compact nature of Scottish society—have a considerable impact, particularly on the young, at whom it is aimed.

He believed that there must be constant monitoring of work in hand, looking at resources to see whether they were being used to the best effect, at management costs, and at the costs of non-medical services. The important thing was to ensure that doctors were aware of the need to use resources effectively. In relation to drug prescribing—a major problem in the NHS—he thought that Scotland was doing well with a bill currently running at around £100m a year.

The factor that helps the NHS work more effectively north of the border is quite simply the Scottish dimension. Life is lived on a smaller scale.