Conclusion

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

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

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Financing the Scottish Health Service

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

Present mechanism

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

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

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

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

Scottish flavour

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

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

presentation of the departmental estimates, annual reports and statistics, and comparisons must therefore be selective. One or two points can perhaps be established without dependence on statistics. In terms of administrative structure, for example, we in Scotland have since 1948 avoided segregating the teaching hospitals in an organisation of their own; similarly health centres have not been segregated as a local authority function; and more recently, since 1974, we have avoided segregating the family practitioner services in "vestigial executive councils." Can we perhaps claim these differences as reflecting a more integrated approach?

Despite the difficulty of making statistical comparisons between England and Scotland, let us examine a few figures taken from the published health statistics which show the breakdown of total health expenditure for 1972-3—that is, before reorganisation (see table).

Health service expenditure 1972-3

	England	Scotland
	(£m)	(£000)
Central Government expenditure:		
Central administration	17 (0.8%)	1521 (0.5%)
Hospitals	1487 (65.9%)	213847 (70.4%)
Executive council services	555 (24.6%)	66204 (21.8%)
Miscellaneous	51 (2.3%)	9526 (3.1%)
Total Government expenditure	2110 (93.5%)	291098 (95.8%)
Local health authority expenditure	147 (6.5%)	12702 (4.2%)
Total Health Service expenditure	2257 (100%)	303800 (100%)

Source: Health and Personal Social Services Statistics for England 1974; Scottish Health Statistics 1973.

Where the money goes

One could argue at length about even this small selection of statistics. It would be tempting, but I think misleading (since it is notoriously difficult to establish the proper attribution of administrative overheads), to claim that the table shows Scottish central administration to be more economical than its English counterpart; and the figures for executive council services need much more analysis to make sense. What does, however, reflect a genuine difference is the higher proportion of expenditure devoted in Scotland to the hospital service: a difference of 4.5%, representing an additional expenditure of the order of £13m. This difference has its counterpart in the relatively much lower level of local health authority expenditure in Scotland. The figures seem to reflect a trend, going back many years, towards a greater concentration of resources on the hospital service in Scotland, based on a different assessment of the country's needs; and, looking back over the years, we can see that the proportion of expenditure devoted to the hospital service has shown a steadily rising trend, no doubt illustrating the limitations on manoeuvre imposed by an established service with its own built-in momentum. Perhaps we can see a reaction against this trend and an attempt to promote the development of the community services in the attention devoted in more recent years to the health centre programme and the building up of the local authority social work services. However this may be, it is clear that the Scottish Health Service has been able to develop its own distinctive patterns, while still providing broadly the same standard of services to patients as in other parts of the United Kingdom.

Within the overall programme the detailed decisions on priority—between one hospital project and another, between one health centre and another, or between a hospital project and a health centre—are taken in Scotland. In this field we can expect the new Scottish Health Service Planning Council to play an increasingly important part.

It is not the function of this background paper to speculate on the effect which devolution may have on these arrangements. Under the proposals in the Government's White Paper,³ the Health Service will become the responsibility of the Scottish Assembly and its executive and will be financed, along with

other devolved services, from the block grant which will be settled each year after discussion between the UK Government and the Scottish administration. Probably the block grant will be built up by a process similar to the present machinery for preparing departmental estimates, giving weight to existing commitments and allowing a relatively small margin for development. The Scottish Assembly will have power to use the block grant as it thinks best. It will be able, for example, to switch resources from one field of expenditure to another; but as a matter of practical politics, given the acquired momentum of existing services, the scope for transfers of this kind will inevitably be limited. It will remain the function of the Scottish Home and Health Department—supported no doubt by the Scottish Health Service Planning Council—to defend and promote the interests of the Health Service against possible competing claims on resources which will necessarily always be limited: a task in which it has not, I think, been entirely unsuccessful in the past.

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View of BMA in Scotland

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The White Paper, *Our Changing Democracy*, was published in November 1975 and has been considered by the committees which represent the profession in Scotland. The Scottish Council collated the views and sent them to the Minister for Health in Scotland. Subsequently the Chairman of the Scottish Council and the chairmen of the main committees met him to discuss the Association's views.

The BMA in Scotland is opposed to devolution and this view is shared to a large extent by the Scottish royal colleges. However, the document produced by the Scottish National Party's Health Policy Committee shows that some doctors in Scotland favour devolution.

Consultants and the universities

We believe that the NHS in Scotland provides a service which, in relation to standards elsewhere in the United Kingdom, is very good. There are four medical schools and three royal colleges in Scotland and, unlike England and Wales, consultants in Scotland work closely with the universities. Most of them are members of the clinical teaching staff and they are also connected, to a varying degree, to the royal colleges. This close relationship with the medical schools and the universities is of great benefit to the Health Service in Scotland. The White Paper does not envisage that the medical schools will be devolved from the University Grants Committee, but the universities, with their senior lecturers and honorary consultants, are very much concerned with Service commitments in Scotland. The general view of many consultants in the university field is that Scottish